Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Giles Harvey, a prisoner at HMP Dovegate, on 9 October 2023

A report by the Prisons and Probation Ombudsman

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

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

T l 020 7633 4100

OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Giles Harvey died on 9 October 2023 after being found hanged in his cell at HMP Dovegate. He was 51 years old. I offer my condolences to Mr Harvey's family and friends.

Mr Harvey had received an Imprisonment for Public Protection (IPP) sentence in 2008. He had been released twice previously but had been back at HMP Dovegate for 14 months, charged with new offences, before he took his life.

In September 2022, the Justice Select Committee found that IPP sentences cause acute harm to those subject to them, with the prospect of serving a sentence without an end date causing higher levels of suicide and self-harm as well as a lack of trust in the system that is meant to rehabilitate them. In September 2023, following a worrying increase in the self-inflicted deaths of IPP prisoners in 2022, I issued a Learning Lessons bulletin on the subject.

Mr Harvey was found hanging the morning on which he was due to attend court for the start of his trial. Mr Harvey had most of the risk factors I identified in my bulletin as increasing the risk of suicide and self-harm in IPP prisoners. Staff gave insufficient weight to those risk factors leading up to his court appearance. In addition, documentation which accompanied Mr Harvey to court did not adequately detail his risks. As a result of a new digital system which recognises triggers, along with monthly reviews, support for IPP prisoners has improved at Dovegate since Mr Harvey died.

Mr Harvey did not receive key worker support in the last seven weeks of his life having previously received good and consistent support. Lastly, we are not convinced that a welfare check took place, as it should have, when staff unlocked Mr Harvey on the morning of his death.

The clinical reviewer concluded that the healthcare Mr Harvey received at Dovegate was of a reasonable standard and equivalent to that which he could have expected to receive in the community.

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

Adrian Usher
Prisons and Probation Ombudsman **January 2025**

Contents

Summary 1

The Investigation Process.....3

Background Information.....4

Key Events.....6

Findings 14

Summary

Events

1. In 2008, Mr Giles Harvey was sentenced to Imprisonment for Public Protection (IPP) with a tariff (minimum time he would have to spend in prison before being considered for release) of three years and six months. He was released from custody in June 2017, but recalled to prison in July 2020. Mr Harvey was released again in December 2021.

2. On 30 July 2022, Mr Harvey was arrested and charged with wounding after an alleged attack on his partner, remanded to custody and taken to HMP Dovegate. As he was an IPP prisoner, his licence was revoked.

3. On 25 November 2022, staff started Prison Service suicide and self-harm monitoring procedures (known as ACCT) after Mr Harvey was found hanging in his cell. He was resuscitated and hospitalised before later returning to prison. He was located in the healthcare in-patient unit under constant supervision supported by regular multidisciplinary ACCT reviews, the mental health team and key work sessions.

4. Mr Harvey did not talk much about why he attempted to take his life, although he said that it was a spontaneous act and his mood was low. However, he spoke about his IPP sentence and feelings of uncertainty around this due to his recall and the court date approaching.

5. Mr Harvey remained under constant supervision until 7 December when his observations were slightly reduced. On 6 January 2023, he was relocated to a standard residential wing. On 27 January, staff closed Mr Harvey's ACCT as they no longer assessed him as a risk to himself. He continued to be supported by the mental health team until May, and regular key work sessions until 22 August.

6. On 9 October, Mr Harvey was due to attend court for the start of his trial. In the morning, when a PCO went to collect him from his cell, she found him hanged behind his cell door. She started cardio-pulmonary resuscitation (CPR). Other staff responded and assisted treating Mr Harvey. Paramedics arrived at 8.17am and shortly after, declared that Mr Harvey had died.

Findings

7. Mr Harvey had a number of risk factors that meant he was at risk of suicide or self-harm including being an IPP prisoner, having been charged with a violent offence against his partner, previous suicide attempts, a family history of suicide and a diagnosis of depression. During his stay at Dovegate, Mr Harvey had highlighted that his IPP status, recall to prison and his court hearings were the source of his frustrations and impacted on his mental health. We consider that while there was some evidence of good, individualised support for Mr Harvey in the early months of his return to Dovegate, staff should have given more weight to the combination of Mr Harvey's risk factors and the ongoing risk he posed to himself, particularly as his court case approached.

8. Mr Harvey had no key work sessions in the seven-week period that led up to the start of his court trial. IPP prisoners should be treated as a vulnerable group and be prioritised for key work.

9. We have some concerns about the quality of the welfare check when Mr Harvey was unlocked on the morning 9 October. It is important that local unlock and welfare check policies are followed.

10. The clinical reviewer concluded that Mr Harvey's healthcare was equivalent to that he could have expected in the community.

Recommendations

- The Director should ensure that PERs are randomly audited to check that they include all relevant risk information.

The Investigation Process

11. HMPPS notified us of Mr Giles Harvey's death on 9 October 2023.

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

13. The investigator visited HMP Dovegate on 17 October 2023. He obtained copies of relevant extracts from Mr Harvey's prison and medical records.

14. The investigator interviewed seven members of staff and one prisoner in November 2023 at Dovegate.

15. NHS England commissioned a clinical reviewer to review Mr Harvey's clinical care at the prison. The investigator and clinical reviewer conducted joint interviews.

16. We informed HM Acting Senior Coroner for Staffordshire South of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

17. The Ombudsman's office contacted Mr Harvey's aunt to explain the investigation and to ask her if she had any matters she wanted us to consider. Mr Harvey's aunt wanted to know all the circumstances that led him to take his own life and whether he was under any supervision at the time. We have covered this in the report.

18. Mr Harvey's family received a copy of the initial report. They did not make any comments.

19. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out one factual inaccuracy and this report has been amended accordingly.

Background Information

HMP Dovegate

20. HMP Dovegate is a Category B prison in Staffordshire, managed by Serco, holding remanded and sentenced adult male prisoners. There is also a therapeutic community, separate to the main prison. Practice Plus Group provides 24-hour healthcare services. Midland Partnership NHS Foundation Trust provides mental health services. Dovegate also has a healthcare in-patient facility.

HM Inspectorate of Prisons

21. The most recent inspection of HMP Dovegate was in September to October 2023. Inspectors reported that Dovegate was failing to fulfil its role as a training prison. While most of the long-term population was in work or education, many jobs were on the wings where prisoners were underemployed and spent much of their time with not enough to do.

22. Inspectors highlighted that Dovegate provided creative support to reduce prisoners' risk, which was complemented by a good range of offending behaviour programmes. HMIP noted that Dovegate's operation of the key work scheme was the best they had seen in recent years in the male prison estate. Shortages of staff, however, meant that prison offender managers were often stretched and regular meetings with prisoners did not take place. They also noted that nearly a third of prisoners left the prison homeless.

Independent Monitoring Board

23. 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 2023, the IMB reported that there was still a number of IPP prisoners at Dovegate and a clear strategy on how IPP prisoners could progress to release was much needed. The report noted that the number of remand prisoners had increased. Some prisoners had been on remand for over 12 months, with no court date yet given. It suggested that a focus on clearing the back log of court appearances for remand prisoners would be beneficial.

Previous deaths at HMP Dovegate

24. Mr Harvey was the eleventh prisoner to die at Dovegate since October 2020, and the fourth prisoner to take his own life in that time. There were no significant similarities between Mr Harvey's death and those of the other prisoners.

Assessment, Care in Custody and Teamwork (ACCT)

25. Assessment, Care in Custody and Teamwork (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 multidisciplinary review meetings involving the prisoner.

26. As part of the process, a care plan (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the care plan 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.

Imprisonment for public protection (IPP) sentences

27. Imprisonment for public protection (IPP) sentences were introduced in 2005 and abolished in 2012. They were intended to protect the public against offenders whose crimes were not serious enough to merit a normal life sentence, but who could only be released once they had served their minimum tariff and had demonstrated to the satisfaction of the Parole Board that they had sufficiently reduced their risk. The abolition was not applied retrospectively. There are about 3,000 IPP prisoners, of which half have never been released.

28. Since June 2022, the Secretary of State for Justice must approve all Parole Board recommendations for the release or return to open conditions of prisoners serving indeterminate sentences.

29. In September 2022, the Justice Select Committee (JSC) published a report of its review of IPP sentences. The JSC found that the indefinite nature of the sentence contributed to feelings of hopelessness and despair that had resulted in high levels of self-harm and some suicides within the IPP population. They recommended that all IPP prisoners be re-sentenced.

30. In February 2023, the Government announced that it would not re-sentence IPP prisoners. In response to the JSC report, the Ministry of Justice (MOJ) and HMPPS published a new IPP action plan in April 2023. The aim of the plan is to focus on ensuring that HMPPS processes support IPP prisoners to "maximise their prospects of achieving a safe and sustainable release".

31. In September 2023, we issued a Learning Lessons Bulletin on the self-inflicted deaths of IPP prisoners after 2022 saw the highest number of these deaths since the sentence was introduced. We concluded that an IPP sentence should be considered as a potential risk factor for suicide and self-harm. We also identified a number of risk triggers associated with IPP prisoners including parole hearings, prison transfers and change in security categorisation.

Key Events

32. In 2008, Mr Giles Harvey was sentenced to Imprisonment for Public Protection (IPP) for offences of wounding and other acts endangering life. He was required to serve a minimum of three years and six months in prison. Mr Harvey was released from prison, on licence, in June 2017. However, he was recalled to prison in July 2020 and taken to HMP Dovegate. Mr Harvey was released again, on licence, in December 2021.

HMP Dovegate

33. On 30 July 2022, Mr Harvey was arrested for offences of wounding with intent (after he had allegedly stabbed his partner), threats to kill and dangerous driving. He attended court, was remanded and taken to HMP Dovegate. As he was an IPP prisoner and on licence, his licence was revoked.

34. When he arrived at Dovegate, the digital Person Escort Record (PER) that accompanied Mr Harvey, indicated that he had been recalled to prison for a violent offence. It noted that Mr Harvey had no suicide or self-harm history and no mental health concerns.

35. A nurse completed Mr Harvey's reception health screen. Mr Harvey denied any history of attempted suicide or self-harm and said he had no past mental health issues. He said he was a moderate social drinker and previously used illicit substances. (Mr Harvey's medical record showed that he had been prescribed antidepressants in 2003 and 2007).

36. On 2 August, a Prison Custody Officer (PCO) conducted a key work session. Mr Harvey said that he had felt safe and supported since he had arrived at Dovegate. He was familiar with the prison system, had completed his induction and had no concerns. He said that he had some pain due to a car crash he had been in before he was arrested.

37. On 17 and 23 November, a PCO conducted key work sessions. She noted that Mr Harvey had been relocated to D Wing, had settled well, obtained a job in the prison workshop and was compliant with the regime.

38. On 25 November, staff found Mr Harvey hanging in his cell. Staff radioed an emergency code blue (used when a prisoner is unconscious or has breathing difficulties). Healthcare staff arrived, resuscitated Mr Harvey and he was taken to hospital. Staff started ACCT procedures.

39. Mr Harvey was discharged from hospital on the same day. When he returned to Dovegate, he was located in the in-patient unit and placed under constant supervision in a gated cell (open bars rather than a solid door to allow for greater staff supervision). A custodial operations manager (COM) spoke to Mr Harvey who said he had acted spontaneously. He said he did not have any further thoughts of suicide or self-harm.

40. The next day, 26 November, a nurse from the mental health team assessed Mr Harvey. Mr Harvey said he had had no previous contact with mental health services

nor had he been prescribed any medication. He said his mood was low and stated that he had attempted to take his life because he had "had enough". He refused to elaborate on this any further. The nurse recorded that Mr Harvey displayed no evidence of distraction or thought disorder and he denied having any psychotic symptoms. The nurse updated prison staff and ACCT documentation. She recorded her assessment clearly in Mr Harvey's medical record.

41. The COM chaired a multidisciplinary ACCT review. Staff noted that Mr Harvey appeared "extremely emotionless and without hope". The COM tried to explore what Mr Harvey's main triggers were to self-harming. Mr Harvey said that he was a private man, and that he would sort things out in his head. He disclosed that other family members, including his mother, had taken their lives. Mr Harvey agreed to receive support from the mental health team. Before the review, the COM had checked Mr Harvey's records and found that he had a male friend who he had known for over 40 years. The COM asked Mr Harvey if he would welcome some form of contact from his friend, for support. Mr Harvey said that this would help him enormously. The COM agreed to try and contact Mr Harvey's friend to arrange a phone call or visit. Staff noted that Mr Harvey would remain under constant supervision.

42. On 25 and 27 November, GPs assessed Mr Harvey. They concluded he had no physical health concerns, nor did he require any mental health related medication.

43. On 27 November, a nurse assessed Mr Harvey. The nurse tried to engage Mr Harvey to talk about his recent suicide attempt. While Mr Harvey said that he did not remember much about the incident, he also hinted that he did not regret what he had done and "that he did not want to be there". She recorded that he remained at high risk of suicide and would remain under constant supervision.

44. On the same day, the COM, who had managed to track down Mr Harvey's friend, facilitated a telephone call between the two. Mr Harvey spoke to his friend for around 15 minutes.

45. On 28 November, the COM chaired a multidisciplinary ACCT case review. Mr Harvey told staff that he was unhappy that he was still alive. However, he said that due to him being in physical pain following his attempted suicide, he was not considering repeating his actions at that time. He said he did not want to talk about any issues as he was a private person. Mr Harvey remained under constant supervision. In the afternoon, Mr Harvey told a nurse that his attempted suicide had not been a cry for help and that he would 'definitely' do it again. His rationale for this was that he had '99 years' on his sentence and had nothing to live for.

46. On 29 November, a psychiatrist assessed Mr Harvey. Mr Harvey told him that there was no particular reason or trigger for his suicide attempt, but he had felt frustrated and annoyed at his situation. He said he had never experienced those feelings before and was still trying to process them. He said he was embarrassed that he had not succeeded in killing himself. Mr Harvey reiterated to the psychiatrist that he had had no previous contact with the mental health services. The psychiatrist did not provide a conclusion to his consultation.

47. The COM chaired a multidisciplinary ACCT review on 30 November. He noted that Mr Harvey's mood was different. He said that he did not want to die and that time

had allowed him to think about his situation. He said he had recently spoken to his aunt for the first time in over 20 years.

48. A PCO conducted a key work session. She noted that Mr Harvey still remained withdrawn and did not want to talk about his mental health but said he had had no more thoughts about harming himself.

49. On 5 December, another COM conducted a multidisciplinary ACCT review. Mr Harvey had apparently managed to speak to his partner (the alleged victim of his recall offence, who he was not supposed to have direct contact with) on the phone the previous day. He said that this had had a positive impact on him and that their conversation had changed his perspective. Mr Harvey explained that during the police pursuit before his arrest, he had driven his car at a wall, with the intent to end his own life. Mr Harvey was still not forthcoming about the triggers for his suicide attempt. When asked about his family, Mr Harvey said he had not had any contact with his children for some time. He spoke about what he would do after he was released from prison.

50. On the morning of 7 December, a trainee psychologist conducted a welfare check on Mr Harvey, before his intended ACCT review. On this occasion, Mr Harvey spoke openly about his situation. He talked about his IPP sentence and the uncertainly that he felt around this due to his recall and his forthcoming court hearing. He spoke about his partner and his business that he managed. Mr Harvey said that all these issues had overwhelmed him and led him to try and take his own life. He said he had no current thoughts of suicide and was fed up with being under constant supervision and people watching him all the time.

51. Shortly afterwards, a COM chaired a multidisciplinary ACCT review. Mr Harvey said that he felt much better and had spoken to his family, his partner and friends on the phone. The COM warned Mr Harvey that due to public protection measures in place, he was not permitted to speak his partner (the prison took appropriate action to remove from Mr Harvey's list of approved numbers the one through which he had contacted her). Mr Harvey said he had no thoughts of suicide or self-harm. Staff reduced his observations to four per hour during the day and five during the night. He remained on the in-patient unit.

52. Records show that Mr Harvey continued to be supported by ACCT procedures and reviewed regularly by his keyworker. Staff noted that Mr Harvey's mood appeared good and he had started to make plans on how to occupy his time when he was returned to a standard residential wing. He also started to go to the gym. Mr Harvey told staff that he worried about his IPP status. On 19 December, staff reduced Mr Harvey's ACCT observations to three per hour.

2023

53. On 4 January 2023, staff reduced Mr Harvey's ACCT observations to two an hour. On 6 January, Mr Harvey relocated to G Wing, a standard wing. The trainee psychologist noted that Mr Harvey appeared positive, although he still had concerns about his future as an IPP prisoner.

54. A COM conducted a welfare check on Mr Harvey on 8 January. He noted that Mr Harvey appeared to be thriving on G Wing and had received some excellent support from other prisoners. Mr Harvey said he was sleeping much better now.

55. On 10 January, a PCO conducted a key work review. Mr Harvey said that he had settled on G Wing. He had no thoughts of suicide or self-harm but was not happy being disturbed during the night by staff conducting ACCT checks. The PCO talked about his IPP status. Mr Harvey said that until he knew his fate, he would always worry about it. He said that being an IPP prisoner affected his mental health. He said he wanted to speak to his solicitor to get some legal advice before his court hearing.

56. On 11 January, a COM chaired a multidisciplinary ACCT review. Mr Harvey talked about his upcoming court case on 16 January. He stated that if he was found guilty, he would deal with it and believed he was in a much better place now. The COM had checked prior to the meeting whether Mr Harvey had recently used his prison phone to make any calls and he had not. However, when asked if he had been using the phone to maintain contact with friends and family, Mr Harvey said that he had. The COM was not sure why Mr Harvey was not telling the truth and noted that he still presented with some risk due to him saying one thing and doing another. His ACCT observations remained at two each hour.

57. On 13 January, Mr Harvey moved to B Wing.

58. At the multidisciplinary ACCT review on 17 January, the COM noted that Mr Harvey's trial should have started the previous day but was delayed for an unknown reason. A prison offender manager (POM) agreed to check why his court case had not started. The staff agreed that Mr Harvey's risk was minimal and lowered his ACCT observations to one an hour. Staff scheduled Mr Harvey's next ACCT review for 27 January, which would allow time for his court case to start and his risk be re-assessed.

59. Shortly afterwards, a PCO conducted a key work session. They talked about his pending trial. Mr Harvey said that he intended to plead not guilty to the wounding charge. The PCO noted that Mr Harvey appeared positive and talked about his house, family and the business that he ran. He said he did not have a lot of support outside of prison as he had no contact with his father, his mother had taken her own life and his brother had died in a car accident. He said he was in telephone contact with a friend. He said he spent most of his spare time watching television and reading. Once his court trial had concluded, he said he wanted to start working again.

60. The PCO conducted a key work session on 25 January. Mr Harvey's court trial had been adjourned for four to six weeks to allow him time to appoint a new legal team, which he had now done. He said he was aware that, irrespective of whether he pleaded guilty or not, he would remain in custody due to his IPP sentence until the completion of the court case. He said that his IPP sentence was the main cause of his mental health issues and he was unsure how he would react if he was found guilty at court. He said he had no current thoughts of suicide or self-harm and said that he had no issues with drugs or alcohol.

61. A COM conducted an ACCT review on 27 January. Staff noted that Mr Harvey was in a good mood, had been socialising with other prisoners and started to exercise. Staff decided that Mr Harvey no longer needed to be supported by ACCT procedures but reminded him that he could ask for support if he felt he needed it.

62. On 11 February, a PCO introduced herself to Mr Harvey as his new key worker. She noted that Mr Harvey was settled on the wing, felt safe and kept himself occupied by socialising with other prisoners and exercising. Mr Harvey told her that his court trial was scheduled to take place around September 2023. Mr Harvey continued to receive key work sessions. Staff raised no concerns about him.

63. On 4 April, a nurse saw Mr Harvey and recorded that he looked well and he said he felt good within himself. Mr Harvey was complimentary about the mental health support that he had received and stated that he had been in a very dark place. He said he had no thoughts of suicide or self-harm.

64. On 17 May, staff discharged Mr Harvey from the mental health team. Mr Harvey was sent a discharge letter which explained his discharge and provided him with contact details should he wish to self-refer to the service in the future.

65. On 30 May and 17 August, Mr Harvey attended court. On both occasions, the PER that travelled with him contained no reference to Mr Harvey's potential risk of suicide. On both occasions, he did not return to the prison via the healthcare reception area for a post-court screening to be completed so no one assessed his mood or risk to self following the court appearances. Mr Harvey's court papers noted that he was scheduled to return to court on 9 October 2023.

66. Between June and July, Mr Harvey's key worker continued to see Mr Harvey for key work sessions. Mr Harvey said that he was happy on G Wing. He did not have a job but occupied his time by socialising with a small group of friends on the wing, watching television and exercising. Mr Harvey said he maintained contact with his friend and family by phone.

67. On 19 August, another PCO completed a key work session. The PCO told us that staff had no concerns about Mr Harvey. He mainly stayed in his cell and had a small circle of friends. On 22 August, the PCO conducted another a key work session. She noted that Mr Harvey was well and she had no concerns about him. Mr Harvey told the PCO that he had no thoughts of suicide or self-harm. This was the last key work session Mr Harvey had as his previous key worker was injured and deployed to administrative duties rather than prisoner-facing ones.

68. On 3 September, Mr Harvey phoned his friend. They had a general conversation. Mr Harvey's friend told him that he had sent him some money. Mr Harvey was grateful. Mr Harvey talked about the prison regime and that he had been locked up all day due to low staff resources. On 17 September, Mr Harvey phoned his friend again. They had a general conversation. Mr Harvey said he was bored but was okay.

69. On 24 September, Mr Harvey phoned his friend twice. Mr Harvey said he intended to borrow some money from another prisoner for canteen. His friend told him that he would send him some money mid-week and would put it into the other prisoner's account. In their second conversation, Mr Harvey told his friend that the prisoner

had agreed to lend him some money and therefore there was no rush for his friend to send him the money that he had promised. Mr Harvey talked about his concerns about his IPP status.

70. On 3 October, the POM saw Mr Harvey and provided him with documents relating to his yearly review of his public protection status. The POM told us that Mr Harvey raised no concerns about the paperwork and was "bright and chatty". He told the POM that he was due to attend court the following week. She noted that she would check Mr Harvey the next week as he might have mental health concerns as a result of his court appearance. The POM's contact with Mr Harvey was recorded on a separate database and not in his main prison records.

71. Mr Harvey was due to attend court on Friday 6 October. (The PER that was completed contained no reference to Mr Harvey's potential risk of suicide or his IPP status.) A PCO told the investigator that when she went to collect Mr Harvey to escort him to the prison reception, Mr Harvey refused to go. Mr Harvey signed a disclaimer regarding his non-attendance.

72. The prisoner who lived in the cell next door to Mr Harvey told us that Mr Harvey had said that he did not see the point in going to court that day as it was a preliminary hearing and nothing would happen there. Mr Harvey told the prisoner that his actual trial was due to start on Monday.

73. A PCO told us that, later that morning, another PCO (unknown) had stated that Mr Harvey should be brought over to the court video-link suite for a hearing. When the PCO went to collect Mr Harvey, he was not in his cell. She found him hiding and laughing in another prisoner's cell. While Mr Harvey initially said that he did not want to attend the video-link suite, he then agreed to go. The PCO told us that she had no concerns about Mr Harvey when he returned from the video-link. She did not record any of this information in Mr Harvey's prison record.

74. Over the weekend (Saturday 7 October – Sunday 8 October), staff raised no concerns about Mr Harvey. A PCO told us that Mr Harvey socialised with other prisoners and played pool. The prisoner who lived in the cell next door to Mr Harvey told us that Mr Harvey gave him no indication over the weekend that he had any concerns. This prisoner spoke to Mr Harvey around 4.00pm on 8 October, shortly before prisoners were locked into their cells for the night. Mr Harvey talked a little about his upcoming trial but again, raised no concerns.

Events on 9 October

75. At 5.03am, CCTV shows the night duty officer conducted her routine check of the wing. She used a torch and looked through Mr Harvey's cell observation panel. She raised no concerns.

76. The prisoner who lived in the cell next door to Mr Harvey told us that at 6.00am, he heard a "big bang" from the connecting wall between his and Mr Harvey's cell. This was followed by a tapping on the wall. He was unsure what the noise was or exactly what Mr Harvey may have been doing in his cell.

77. A PCO started her duty at 6.45am. After a short staff briefing, at which it was identified that Mr Harvey was due to attend court that day, she started to unlock prisoners on G Wing for exercise.

78. CCTV shows the PCO arrived at Mr Harvey's cell at 7.02am. She unlocked and slightly opened the cell door in a very swift motion, before moving onto unlock the next cell. At interview, the PCO told us that although she had only slightly opened the cell door, she saw that Mr Harvey was on his bed. She said good morning to him and he nodded in acknowledgement.

79. The prisoner who lived in the cell next door to Mr Harvey told us that when the PCO unlocked his cell door that morning, she did not open his cell door, nor look through his observation panel or engage with him, to conduct a welfare check.

80. After unlocking prisoner cells on the same side as Mr Harvey's cell, CCTV shows the PCO unlocking prisoners on the opposite side of the landing. She did not look through the prisoners' observation panels or engage with them.

81. Around 7.40am, reception staff phoned G Wing and asked that Mr Harvey be brought to the reception area, as he was due to go to court. A couple of minutes later, a PCO got to Mr Harvey's cell and pushed the door slightly open. She said the door felt a little strange but did not think more about this. Mr Harvey was not in his bed and so she left to find him as she believed he was not in his cell. Given that Mr Harvey had hidden from the PCO a few days earlier because he did not want to go to court, she thought that he may be doing so again.

82. The PCO quickly checked the cell she had found Mr Harvey in the last time he was hiding. He was not there. She looked in the cell where another of Mr Harvey's friends lived, but he was not there either. She could not see him on the wing landings and therefore returned to Mr Harvey's cell. On this occasion, she pushed the cell door with a little more force but the door would not open fully as something behind it was causing an obstruction. The PCO stepped into the cell and immediately saw Mr Harvey hanging from a ligature on the inside of the door. She stepped out of the cell and radioed a code blue emergency immediately. Control room staff recorded that this occurred at 7.45am and called an ambulance immediately.

83. Prisoners, including the prisoner who lived in the cell next door to Mr Harvey, that were on the landing heard the PCO call the emergency alarm. The prisoner next door to Mr Harvey immediately helped the PCO support Mr Harvey's body while another prisoner loosened the ligature from the other side of the door. Mr Harvey had used a shoelace as the ligature and had tied a knot within the opening of the door.

84. The PCO, assisted by the prisoners, placed Mr Harvey on the cell floor. She cut the ligature from around Mr Harvey's neck and checked him for any signs of life, but found none. She started cardiopulmonary resuscitation (CPR). Other staff responded including a PCO who alternated CPR with the PCO who radioed the code blue.

85. Body-worn camera footage shows that a healthcare assistant and nurse arrived at the cell at 7.49am. They used medical equipment to manage the care of Mr Harvey

while staff continued CPR. Further healthcare and prison staff arrived and assisted. The paramedics arrived at 8.17am and took over Mr Harvey's care. At 8.48am, they confirmed Mr Harvey had died.

86. After Mr Harvey's death, staff found two letters in his cell addressed to a friend. In the first letter, Mr Harvey had written 'I told [name] there would be no trial I stick to my word' and 'I've tried ending it before, I can't even do that right'. In the second letter, he said that he had made two previous suicide attempts in prison.

Contact with Mr Harvey's family

87. The prison appointed the Equalities Manager and a PCO as family liaison officers. At around 11.00am, they visited Mr Harvey's aunt's house and broke the news of Mr Harvey's death. Mr Harvey's aunt said she would inform other family members of Mr Harvey's death. Dovegate contributed to funeral costs in line with national instructions.

Support for prisoners and staff

88. The prison posted notices informing other prisoners of Mr Harvey's death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by his death.

89. After Mr Harvey's death, the staff involved in the incident were given the opportunity to discuss any issues arising and were also offered support by the staff care team.

Post-mortem report

90. At the time of writing this report, the post-mortem and toxicology reports were not available.

Findings

Assessment of risk

91. Mr Harvey was an IPP prisoner, recalled to prison charged with further offences. In our Learning Lessons Bulletin issued in September 2023, we concluded that more needs to be done to recognise a prisoner's IPP status as a potential risk factor for suicide and to identify the triggers for suicide and self-harm that are associated with this status. 2022-2023 was a significant year for IPP prisoners. In June 2022, the Secretary of State for Justice tightened the criteria for transfer to open prisons and introduced ministerial approval of Parole Board recommendations for these transfers. In February 2023, the Government announced they would not accept the JSC recommendation to re-sentence all IPP prisoners.

92. Mr Harvey had a number of additional risk factors, he had been charged with a violent offence against his partner, had previously attempted suicide, had a family history of suicide and a history of depression. Mr Harvey was subject to ACCT support, including a long period under constant supervision, for around eight weeks at the end of 2022 and start of 2023. This was of a high quality, with a consistent case manager, multi-disciplinary working and a holistic consideration of Mr Harvey's risks.

93. Once Mr Harvey's ACCT was closed in January 2023, except for his key work sessions, he was not provided with any additional or specific support in respect of his IPP status. This was despite risk assessments in 2022 and early 2023 noting that his thoughts of suicide and self-harm would need on-going monitoring because he continued to worry about his recall to prison, his IPP status and upcoming court trial. Mr Harvey stated that his IPP sentence was the main issue that impacted on his mental health. While he was unsure how he would react if he was found guilty at court, he also knew that irrespective of the outcome, he would remain in prison for some time. Indeed, shortly after his suicide attempt in November 2022, he stated that he would "definitely" attempt suicide again at some point because he had years left on his sentence and nothing to live for.

94. Mr Harvey had repeatedly told staff that he was worried about his court case and the impact of his IPP status. He took his life on the day his trial was due to start, which had been noted as a cause for concern when he had first arrived back at Dovegate. He also referred to this being a trigger for him in the notes found in his cell after he died. We consider that there was sufficient cause for staff to have assessed Mr Harvey as at an ongoing risk of suicide and self-harm and ensured regular support was available to him, particularly in the lead up to and early days of his trial.

95. HMIP noted that Dovegate had recently resumed monthly reviews for IPP prisoners, with support from the forensic psychology team, to identify actions to help these prisoners to progress. This was discussed with the Assistant Director, who informed us that along with this, Dovegate had developed a new digital system which provided alerts to both prison and healthcare staff of potential risks to prisoners from triggers, such as court hearing dates and birthdays. This is a positive development. However, we emphasise the importance of embedding these IPP monthly reviews at Dovegate and staff ensuring that they are aware of their

responsibilities with regards to the trigger system. The Director may also wish to consider introducing a regular forum for IPP prisoners which has been successfully run at other prisons.

96. In response to the JSC report, the Ministry of Justice (MOJ) and HMPPS published a new IPP Action Plan in April 2023. The aim of the plan is to focus on ensuring that HMPPS processes support IPP prisoners to "maximise their prospects of achieving a safe and sustainable release." It includes measures to support those serving IPP sentences and to reduce the risk of suicide and self-harm.

97. The IPP Action Plan includes a requirement for Executive Directors to introduce IPP Delivery Plans for the prisons in their regions by the end of April 2024. It is important that these plans contain meaningful actions to support IPP prisoners through to release if we are to stop seeing more IPP prisoners taking their own lives.

PER documentation

98. The DPER documentation which staff completed before Mr Harvey's attendance at court hearings on 30 May, 17 August, 6 October and 9 October 2023, contained no reference to his potential risk of suicide or IPP status. This is not in accordance with PSI 64/2011 (updated July 2021) which states clearly that all potential risk information should be identified on transfer documentation. We make the following recommendation:

The Director should ensure that PERs are randomly audited to check that they include all relevant risk information.

Key Worker Scheme

99. Our Learning Lessons Bulletin concluded that IPP prisoners should be considered vulnerable and prioritised for key work. From his arrival at Dovegate until August 2023, Mr Harvey had regular key work sessions and these particularly supported him while being monitored under ACCT procedures. However, prior to his death, his last key work session was on 22 August. His key worker was unable to fulfil her key working duties because she was initially on annual leave and then deployed elsewhere in the prison due to an injury.

100. Mr Harvey was not reassigned a new key worker and therefore did not have any further key work sessions in the seven-week period leading up to his death and during the period when his court trial was due to begin. This was a stressful period for Mr Harvey.

101. The Assistant Director told us that Dovegate averaged 2,000-3,000 key work sessions each month and the circumstances of key work not being completed for Mr Harvey in the weeks prior to his death was not a common occurrence. This view is certainly supported by the recent HMIP inspection which described Dovegate's key work scheme as one of the best they had seen.

102. Since Mr Harvey's death, Dovegate have introduced an additional safety check to ensure that if a key worker is absent, a secondary key worker is deployed to cover their duties. We therefore make no recommendation.

Unlock procedures

103. Dovegate's local procedures outline that staff should conduct a physical check of prisoners during roll counts, welfare checks and when they are unlocked or locked into their cells.

104. The PCO said that when she unlocked Mr Harvey's cell at 7.02am, she saw that Mr Harvey was on his bed, said good morning to him and he nodded acknowledgement. Mr Harvey's bed was located on the left-hand side of the cell, the same side as his cell door opens. However, CCTV footage shows that when the PCO unlocked the door, she moved on very quickly.

105. The CCTV view of the cells on the opposite side of the landing is clearer and it is evident that the PCO did not do a welfare check when she unlocked any of these prisoners straight after Mr Harvey. Additionally, the prisoner in the cell next door to Mr Harvey said that the PCO did not open his door when she unlocked it, or observe or engage with him. Given all of this and the loud noise that the prisoner in the cell next door heard at 6.00am, we consider it unlikely that the PCO's welfare check of Mr Harvey that morning was adequate and it is possible that he may have been hanging at that time.

106. Following Mr Harvey's death, senior managers spoke to the PCO about her actions and sent a notice to staff outlining expectations when conducting roll checks, welfare checks or unlocking prisoners. We make no further recommendation.

Clinical care

107. The clinical reviewer concluded that overall, the healthcare that Mr Harvey received at Dovegate was of a good standard and was equivalent to that which he could have expected to receive in the community. While the clinical reviewer has raised some procedural concerns that related to healthcare assessments, systems and processes, these were not considered to have contributed to Mr Harvey's death. The Head of Healthcare will wish to address these concerns which are detailed further below.

Head of Healthcare to note

Mental health care

108. During his reception screening on 1 August 2022, Mr Harvey stated that he did not have a history of mental health issues. However, the clinical reviewer noted that Mr Harvey had had contact with a GP in 2003 and again in 2007, where he was described as depressed and treated with antidepressant medication. For whatever reason, Mr Harvey did not disclose this information to healthcare staff at Dovegate. The Head of Healthcare will want to ensure that staff consult past medical records when making their assessments.

109. Mr Harvey made a very serious suicide attempt in November 2022, which resulted in him being monitored by ACCT procedures and supported by the mental health team. He was not diagnosed with any mental illness and although he was also seen

by the psychiatrist, the psychiatrist did not record a conclusion or a recommended care plan.

110. The clinical reviewer also noted that although the mental health assessments undertaken for Mr Harvey were clear, staff did not complete the Midland Partnership Foundation Trust (MPFT) mental health questionnaire template as they should have done, nor record/use mental health assessment tool scores, in order to provide an initial benchmark assessment of Mr Harvey's mental health status to help support him better. The Head of Healthcare will want to address these issues.

Inquest

111. An inquest was concluded on 15 January 2025 which concluded that Mr Harvey's death was due to suicide by hanging. The coroner gave a verdict in which he said:

"A combination of facing the victim and her family in court, the IPP sentence, and any additional sentence contributing to him taking his own life."

Prisons & Probation Ombudsman
Independent Investigations

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

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

T l 020 7633 4100