Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Simon Lightfoot, a prisoner at HMP Dovegate, on 29 April 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 I 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 Simon Lightfoot was found hanged in his cell at HMP Dovegate on 29 April 2023. He was 52 years old. I offer my condolences to his family and friends.

Mr Lightfoot spent just two weeks at Dovegate. He appeared to have settled well but in telephone calls and texts to his partner, he became increasingly stressed and expressed worries about his family, the running of his business and the possibility of spending many years in prison. However, there is no evidence that Mr Lightfoot shared his concerns with prison staff.

The clinical reviewer concluded that the healthcare Mr Lightfoot received at Dovegate was equivalent to that which he might have expected to receive in the community. However, the nurse who helped staff try to resuscitate Mr Lightfoot did not feel confident enough to stop resuscitation efforts, even though it was clear that he had already died.

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 **June 2024**

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Summary

Events

1. On 14 April 2023, Mr Simon Lightfoot was remanded to HMP Dovegate. It was his first time in prison.

2. During his short time at Dovegate, Mr Lightfoot seemed to settle quickly. He appeared to get on with his cellmate, participated in the prison regime, worked daily, mixed with other prisoners, went to the gym, and received a visit from his partner.

3. In telephone calls and text messages to his partner, family and friends, Mr Lightfoot sounded increasingly stressed and anxious about his family's welfare, his business, court proceedings and the possible length of his sentence. Staff did not know about these concerns.

4. At around 8.00am on 29 April, Mr Lightfoot's cellmate woke to find him hanging from the ladder of their bunk bed and raised the alarm. Mr Lightfoot had tied a ligature, made of a blue nylon rope, around his neck. Although the officer who responded first did not call an emergency code blue, staff responded quickly to his call for assistance, went into the cell, cut the ligature, and called a code blue.

5. The officers and emergency response nurse tried to resuscitate Mr Lightfoot, despite the presence of rigor mortis. Paramedics arrived at around 8.26am and confirmed Mr Lightfoot's death two minutes later.

Findings

6. Mr Lightfoot did not display any behaviour that indicated that he was at risk of suicide or self-harm and did not present with any new risk factors in the days before his death. Although Mr Lightfoot expressed anxiety about his family's welfare, business and court proceedings with his family, he never shared his feelings with staff. Staff at Dovegate therefore reasonably concluded that Mr Lightfoot did not need to be monitored under suicide and self-harm monitoring procedures (ACCT).

7. When Mr Lightfoot was found, staff immediately started cardiopulmonary resuscitation (CPR). These attempts continued after the emergency response nurse arrived. Although the nurse quickly recognised that rigor mortis was present, she did not feel confident enough to stop resuscitation efforts, even though it was clear that Mr Lightfoot had already died.

Recommendations

- The Head of Healthcare should ensure that all agency staff commissioned by Practice Plus Group (PPG) have sufficient training and competency to stop or not attempt CPR when it is evident it is futile.

The Investigation Process

8. The Prisons and Probation Ombudsman (PPO) was notified of Mr Lightfoot's death on 29 April 2023.

9. 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.

10. The investigator obtained copies of relevant extracts from Mr Lightfoot's prison and medical records.

11. NHS England commissioned a clinical reviewer to review Mr Lightfoot's clinical care at the prison.

12. The investigator interviewed eleven members of staff at HMP Dovegate, some jointly with the clinical reviewer.

13. We informed HM Coroner for Staffordshire South of the investigation. He provided us with a copy of the post-mortem and toxicology reports. We have sent him a copy of this report.

14. We contacted Mr Lightfoot's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They asked why he had access to a rope in his cell and why he was not checked overnight. Mr Lightfoot's next of kin said that they had spoken to a man released from Dovegate (we were not told his name) who told them that Mr Lightfoot had asked to speak to someone about his mental health, but his requests were ignored. (We found no evidence that Mr Lightfoot had raised concerns about his mental health with healthcare staff.)

15. Mr Lightfoot's next of kin received a copy of the initial report. They did not make any comments.

Background Information

HMP Dovegate

16. 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 (PPG) provides 24-hour healthcare services. South Staffordshire and Shropshire Foundation Trust provides mental health services.

HM Inspectorate of Prisons

17. Inspectors carried out a full unannounced inspection from September to October 2023. They noted that there had been instability at Director level, with seven Directors over a 10-year period. A new Director had taken over in January 2023 but the instability had meant that the prison had not progressed as much as expected in ensuring purposeful activity for prisoners. However, levels of violence were lower than in comparable prisons. Inspectors found ongoing difficulties with recruiting healthcare staff. Staff worked hard to support prisoners to maintain family ties and key work was strong. Inspectors found that Dovegate was reasonably safe. PPO recommendations were monitored but progress in addressing some of them was too slow.

18. Following the previous inspection in October 2019, inspectors noted that Dovegate had improved since their last inspection in 2017. They noted the positive and polite interactions between staff and prisoners, that officers demonstrated a good knowledge of prisoners in their care and that the support prisoners were given to maintain family ties was encouraging, with enhanced family visit arrangements. Inspectors reported that prisoners received good support during their early days at the prison and initial interviews with new prisoners were sufficiently focused on safety.

Independent Monitoring Board

19. 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 annual report for the year to September 2022, the IMB reported that staff treated prisoners with respect, there were generally positive relationships between them, and staff had good knowledge of prisoners in their care.

Previous deaths at HMP Dovegate

20. Mr Lightfoot was the third prisoner to take his life at Dovegate since January 2020. Between then and Mr Lightfoot's death, there were eight deaths from natural causes. There were no similarities between our findings in these investigation reports and those in our investigation of Mr Lightfoot's death. Up to the end of 2023, there has been one self-inflicted death at Dovegate and one drug-related death since Mr Lightfoot's death. There was also one drug related death in July 2020. In our investigation into this death, we identified that staff had attempted CPR, despite evidence that the prisoner had died.

Assessment, Care in Custody and Teamwork

21. 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 prisoners. As part of the process, a care plan which includes support and intervention, should be in place. The ACCT plan should not be closed until all the actions of the care plan have been completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011 on safer custody.

Key Events

22. On 14 April 2023, Mr Simon Lightfoot was remanded to HMP Dovegate. He had no previous convictions, and it was his first time in prison.

23. At around 6.30pm, Mr Lightfoot arrived at Dovegate. At his reception interview, Mr Lightfoot told a Prison Custody Officer (PCO) that he had never harmed himself before and he denied thoughts of doing so. Mr Lightfoot was not considered a risk to himself or others and was assessed as suitable to share a cell. He was moved to the Vulnerable Prisoners' Unit.

24. At around 8.40pm, a nurse completed an exceptional safety assessment (rather than an initial health screen) because it was late in the day. He noted Mr Lightfoot was fully engaged but was nervous and felt "slightly dejected" about being in prison. Mr Lightfoot told the nurse that he had never had mental health concerns, he denied substance misuse issues and "categorically" denied thoughts of self-harm. The nurse told him how to access support at the prison, including from Listeners (prisoners trained by the Samaritans to provide confidential and emotional support). He told Mr Lightfoot that he would be checked regularly overnight, and he should use his cell bell to alert staff if he was struggling with his mental or physical health. He said that Mr Lightfoot presented with no risk to suggest that he should be monitored under suicide and self-harm prevention procedures, known as ACCT.

25. During his first night in custody, Mr Lightfoot was checked hourly. Staff raised no concerns about him.

26. On 15 April, a PCO completed a first 24-hour review. The PCO noted that Mr Lightfoot raised no issues or concerns, and he was reminded of the support available. When asked to score his mood out of ten, with 10 indicating that he was extremely content, Mr Lightfoot assessed his mood as eight and said he was okay.

27. A nurse completed Mr Lightfoot's first night reception screen which had been delayed due to his late arrival the previous day. Mr Lightfoot denied mental health issues and thoughts of suicide or self-harm. The nurse described his mood as normal. A further healthcare assessment took place that afternoon, and it was noted that Mr Lightfoot did not take any prescribed medications.

28. On 17 April, a PCO introduced herself to Mr Lightfoot as his keyworker. She said he was chatty but anxious about his business and being so far from his family. She told him that she would ask about ways in which the prison could offer him additional support. She said she had no concerns about Mr Lightfoot's mental health and did not consider that he was at risk of suicide or self-harm.

29. In a telephone call to his sister, Mr Lightfoot spoke about business and domestic matters, and his alleged offending. He spoke to his partner about similar matters, and they discussed plans for her to visit him. He later exchanged text messages, using the prison's texting service, about her plans to visit. (At Dovegate, prisoners have a telephone and the ability to call and text family and friends from their cell. Although all calls and texts are recorded, staff do not routinely monitor them and therefore prison staff did not know the content of Mr Lightfoot's telephone calls and text messages while at Dovegate.)

30. Between 18 and 25 April, Mr Lightfoot spoke to his partner 32 times and texted her daily. They talked about domestic and business issues and arrangements for her to visit him. Mr Lightfoot discussed his alleged offences and the length of sentence he might receive. During this time, he also spoke to friends and other relatives.

31. In a text to his partner on 19 April, Mr Lightfoot said he did not feel good, did not want to think about things and was worried about being moved to another prison, where he might have less access to a telephone, and it would be harder to text. In a telephone call to his mother, Mr Lightfoot sounded tearful and asked her to be there for his partner and children.

32. On 20 April, Mr Lightfoot started work in the prison's Industries Unit. (Mr Lightfoot attended every session that he could until 28 April.) A workshop instructor gave him an induction. He said that Mr Lightfoot was "quite jolly" and got on well with other prisoners. He said that Mr Lightfoot never mentioned thoughts of suicide or self-harm.

33. In a telephone call to his partner that day, Mr Lightfoot said he was not okay but gave no further details. In a text to her, he said, "my heart is in pain and I'm beginning to stress".

34. On 21 April, the keyworker completed Mr Lightfoot's 72 hours in custody interview, noted no concerns and reminded him of the support available.

35. In texts to his partner that day, Mr Lightfoot wrote that he was "so sad thinking here how long this is going to be after talking to solicitor so sad and afraid [sic]" and that he would miss his sons. He later texted that his head was spinning, he was depressed and being in prison was only going to get worse. His partner texted back words of support.

36. In a telephone call to his partner on 22 April, Mr Lightfoot said, "I can't do this, babe", and spoke again of his fear about being given a long sentence. In a further call, he told his partner about how "hard it was" and how he missed his children. Mr Lightfoot appeared to break down during the call. In another call, Mr Lightfoot said he "was fucked" and despite reassurances from his partner, he repeated the phrase, "What a fucking nightmare" three times before the call ended. Mr Lightfoot continued to sound emotional in calls to his partner that day. During an exchange of text messages, he said, "I'm trying in here but can't do it, I'm trying my best but cannot make it work, I want it finish" [sic]. His partner again provided reassurance and support and told him he would feel better after she had visited him.

37. In a telephone call on 23 April, Mr Lightfoot told his partner that he was "burnt out" and "might as well shut and lock the doors". During the day, Mr Lightfoot continued to exchange several texts with his partner about business arrangements and domestic matters. In one text, Mr Lightfoot said he was "not really okay" and in another, he said he had been to church but did not know why.

38. On 26 April, Mr Lightfoot spoke to his partner. They discussed her proposed visit to see him the next day with their children.

39. On 27 April, Mr Lightfoot's partner visited him. In a telephone call that evening, they talked about arranging a further visit. A PCO said that when Mr Lightfoot returned

from his visit, he was disappointed that his children had not been able to see him but hoped he would see them the following Sunday. (Mr Lightfoot had not realised that his children's names needed to be put on the visiting order.) He said Mr Lightfoot never mentioned thoughts of suicide or self-harm.

40. Mr Lightfoot's cellmate said that two or three days before he died, Mr Lightfoot had said to him, "I lost my family, my business, my everything." He said that Mr Lightfoot had told him, after he had spoken to his solicitor, that he might get twelve years. He said that Mr Lightfoot had said that his alleged victim had ruined his life, and, at one point, he had punched the cell wall in anger.

41. On the morning of 28 April, a PCO carried out a keywork session with Mr Lightfoot, as his keyworker was not available. The officer noted that Mr Lightfoot was settled, got on with other prisoners, maintained contact with family and friends and attended work. He said that Mr Lightfoot was always talking to people about his family and business and had never mentioned to him thoughts of suicide or self-harm or given any indication that he was at risk. He said he was shocked when he learnt that Mr Lightfoot had taken his life.

42. Later that afternoon, Mr Lightfoot spoke to his partner about his court case and her next visit. He also spoke to his sister, told her that he felt "a bit down" and that he might be given a six-year sentence if he pleaded guilty.

43. At around 5.00pm, Mr Lightfoot and his cellmate were locked in their cell for the night.

44. The night officer arrived on the unit at around 7.15pm to start her nightshift. She said that during the handover, no concerns were raised about Mr Lightfoot. At around 7.30pm, she completed the evening routine check but said that neither Mr Lightfoot nor his cellmate raised any concerns.

45. In a telephone call to his partner at 6.12pm, Mr Lightfoot talked about his court case and briefly spoke to his mother. He told her he felt terrible. Mr Lightfoot and his partner exchanged their love for one another, as they always did, and said goodbye. Mr Lightfoot texted his partner as usual that day. He apologised for letting people down and talked of further visits and business matters. Mr Lightfoot sent his last text message to his partner at 11.39pm, saying goodnight. CCTV footage shows that the light in Mr Lightfoot's cell was turned off around ten minutes later.

46. The cellmate said that at around 11.00pm, Mr Lightfoot had asked if he could turn the television off, which he agreed to, but that Mr Lightfoot turned it back on again, checked his texts and went to bed at around midnight. He said that during the night, he heard Mr Lightfoot snoring, he was quite restless, and they both got up to use the toilet during the night.

Events of 29 April 2023

47. At around 5.05am, the night officer checked Mr Lightfoot's cell when she completed a routine morning check. She said that both Mr Lightfoot and his cellmate were in their beds and that nothing in the cell gave her any concern. She handed over to a colleague. She said she raised no concerns about Mr Lightfoot as there were none.

48. The cellmate said that when he woke up at around 8.00am, he looked over the top of his bunk and saw Mr Lightfoot sitting on the floor, with a rope around his neck, which was tied to the bed. He said he rang his cell bell to alert staff at around 8.01am. (On Saturdays, prisoners are not routinely unlocked until 9.00am, unless there is a reason to do so. It is during unlock that officers carry out a welfare check on prisoners.)

49. PCO A said that she was in a wing office at around 8.01am, when she heard knocking coming from one of the cells. When she arrived on the landing, she noticed that Mr Lightfoot's cell bell light was on. (She was not in the main office where the cell bell panel was located and as such did not hear the bell ring. Evidence provided shows that staff in the main office were alerted to a pressed cell bell about 15 seconds before she arrived at the cell.) She arrived at the cell door at around 8.03am and found the cellmate standing at the door. She said he asked for the cell door to be opened so he could be let out. The officer told him that she could not open it as she was on her own.

50. The cellmate stepped to one side and PCO A saw that Mr Lightfoot was in a slumped seated position on the floor, with a ligature around his neck made from a blue nylon rope tied to the bed's ladder. She explained that she could not open the door for safety reasons. (She said she did not enter the cell as she was on her own and was not sure of the circumstances facing her.)

51. PCO A left the cell as she was the only member of staff on the landing at the time and shouted for assistance from her colleagues. She said she also called for urgent assistance by pressing her personal alarm but did not radio a code blue (indicating an emergency medical response was needed). Officers responded immediately and followed her to Mr Lightfoot's cell. PCO B, one of the response officers, said that PCO A sounded distressed. She said she could not recall an alarm being sounded.

52. At around 8.04am, PCO A unlocked the cell door. PCO B went into the cell, followed by her colleagues. PCO B cut the ligature from around Mr Lightfoot's neck, with the help of other officers. She said that Mr Lightfoot was cold, had a mottled appearance and she believed rigor mortis had set in.

53. The officers checked for signs of life but found none. A PCO started CPR. He said that he also believed that Mr Lightfoot had died as his jaw was fixed. PCO B called an emergency code blue at 8.04am, and an ambulance was called at the same time. (The cellmate was taken from the cell at 8.04am and was supported by staff, peers and Listeners. He later saw the prison's bereavement services.)

54. Healthcare staff, having heard a distressed call for assistance, made their way to the unit at around 8.02am. An agency nurse and a nursing associate arrived at the cell at around 8.06am and helped the officers to continue CPR, including using a defibrillator, airway and oxygen.

55. The healthcare staff said that they saw signs of rigor mortis, but they and officers continued CPR until paramedics arrived at 8.26am. After a brief assessment, the paramedics declared at 8.28am that Mr Lightfoot had died.

56. Paramedics arrived at the prison at 8.12am but due to security processes, including gates needing to be unlocked, and Mr Lightfoot's houseblock being at the furthest point away from the prison entrance, they did not reach Mr Lightfoot until 8.26am.

Information received after Mr Lightfoot's death

57. At 11.59am, Mr Lightfoot's son texted him to ask if he was okay as his partner was worried that she had not heard from him.

58. Staffordshire Police confirmed that Mr Lightfoot left written material in his cell. However, the police told the PPO that the contents did not refer to an intention to take his life and did not include a letter to his family. The police confirmed that the notes related to his thoughts and defence about the alleged offence.

Contact with Mr Lightfoot's family

59. At 1.15pm on 29 April, two family liaison officers broke the news of Mr Lightfoot's death to his next of kin. Dovegate offered to contribute to funeral expenses in line with national instructions.

Support for prisoners and staff

60. The Assistant Director invited staff individually to give an account of the emergency and to offer support. The staff care team also offered support. A collective meeting was not arranged.

61. The prison posted notices informing other prisoners of Mr Lightfoot's death and offered support. Staff reviewed all prisoners assessed as at risk of suicide or self-harm in case they had been adversely affected by Mr Lightfoot's death and offered support to other prisoners and staff.

Post-mortem report

62. A post-mortem examination found that Mr Lightfoot died from hanging and that there was no evidence of assault or restraint. Post-mortem toxicology test results showed no evidence of illicit substances in his system.

Inquest into Mr Lightfoot's death

63. The inquest into Mr Lightfoot's death was held on 16 June 2025 and a verdict of suicide was recorded.

Findings

Assessment of Mr Lightfoot's risk

64. PSI 64/2011 on safer custody requires 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. PSI 64/2011 recognises that prisoners are at increased risk of suicide and self-harm during their first days in custody.

65. Mr Lightfoot was not subject to ACCT monitoring during the two weeks he spent at Dovegate. Although it was his first time in prison, he did not have any significant other risk factors when he arrived and had no history of attempted suicide, self-harm or mental health issues. When asked by staff he denied any thoughts of suicide or self-harm. He had significant contact with his partner and others by telephone and text. He did not display any behaviour or present with any new risk factors to indicate to prison or healthcare staff that he was at an increased risk of suicide or self-harm.

66. In the days leading to his death, Mr Lightfoot told his partner and family in telephone conversations and texts that he was stressed and concerned about his family, business matters and sentencing. However, he never shared his feelings with staff and did not raise any specific concerns with them. With the information available to them at the time, staff at Dovegate reasonably concluded that Mr Lightfoot did not need to be monitored under ACCT procedures.

Emergency response

67. It took paramedics fourteen minutes from their arrival at the prison until they were able to assess Mr Lightfoot. This was a very long time, and although in this case it did not impact on the outcome for Mr Lightfoot, in other emergencies such a delay could be critical.

68. We might have made a recommendation on this but on the 7 February 2024, the PPO hosted a roundtable discussion attended by senior representatives from HMPPS and the Ambulance Service. The PPO presented evidence that ambulance access to prisons was a regular issue in our investigations. HMPPS committed to a multi-agency review of their practices, and we await the outcome of that work. We therefore make no recommendation.

Clinical care

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

Cardiopulmonary resuscitation

70. Prison guidance says that resuscitation must be started on all patients who are found not breathing and/or pulseless unless certain conditions (such as the presence of rigor mortis) exist. The European Resuscitation Council Guidelines state that resuscitation is inappropriate when there is clear evidence that it will be futile.

71. CPR continued for around twenty minutes until paramedics arrived, even though it was apparent to healthcare practitioners that rigor mortis was present. The nurse said that she recognised quickly that rigor mortis was present but did not feel confident enough to stop CPR. Healthcare and prison staff did not discuss whether to continue or stop CPR.

72. In our investigation into the death of a man at Dovegate in July 2020, we identified a similar issue about inappropriate resuscitation. The prison confirmed that all healthcare staff had been given guidance during their initial training to ensure they knew when it was appropriate and not appropriate to perform CPR. They told us that additional training had been completed in February 2021.

73. However, the nurse who responded to the emergency was an agency nurse and did not work regularly at Dovegate. The Head of Healthcare told us that all healthcare staff, including agency staff, were trained in immediate life support. She told us that full-time healthcare staff were confident to step down CPR when they believed it was futile and they had received additional training to verify death. However, agency staff had not received this training. We make the following recommendation:

    The Head of Healthcare should ensure that all agency staff commissioned by PPG have sufficient training and competency to stop or not attempt CPR when it is evident it is futile.

Director to note

Access to ligature material

74. The Assistant Director told us that it was unclear where Mr Lightfoot obtained the blue nylon rope that he used as a ligature. However, he said that the industries unit had a contract to produce air bags, and the materials for this were delivered packaged with a blue nylon rope. He told us that staff destroyed the packaging by taking it directly to the compacter.

75. The Assistant Director confirmed that as Mr Lightfoot worked in the Vulnerable Prisoners' Industries Unit 1, he would not have had direct access to the rope or the industries yard where such rope would have passed through. He told us that it was unlikely that a member of staff would have stored rope in Industries Unit 1.

76. Dovegate concluded that it was possible that a prisoner had obtained the rope and taken it out of the unit. The prison acknowledged that this raised serious concerns as rope could be used to self-harm or as an escape aid.

77. The Assistant Director said that following Mr Lightfoot's death, all staff in the Industries Units had been briefed about the importance of vigilance in disposing of

ropes and searching prisoners thoroughly before they left the industries units. The prison also said that the materials involved were no longer packaged with nylon rope but wrapped with plastic. We therefore make no recommendation about this matter.

Calling an emergency code blue

78. PCO A said she initially did not try to radio a code blue because her radio was faulty. She said that the battery had fallen out of her radio, and this happened regularly. She said that as her colleagues were nearby, she shouted for help as she believed this would be quicker.

79. The response to PCO A's shouts for assistance were prompt and, on this occasion, there was no impact on the emergency response or eventual outcome in a code blue not being called. However, the Director may want to take action to ensure that radios work so that they do not prevent staff from carrying out their duties appropriately.

Paramedic access

80. In their report, paramedics reported on the delay in reaching Mr Lightfoot from when they arrived at Dovegate. Paramedics arrived at the prison at 8.12am but reported that due to security processes and gates having to be unlocked it took 14 minutes for them to reach Mr Lightfoot's cell. We also note, however, that Mr Lightfoot's cell was located on a houseblock at the furthest point from the vehicle entrance. Although the delay did not impact on the outcome for Mr Lightfoot, the Director should satisfy himself that all staff are aware of the procedures to ensure immediate and swift entry to the prison by emergency services.

Hot debrief

81. Although the healthcare and prison staff who spoke to us said that they did not have a collective immediate hot debrief after Mr Lightfoot's death (as should take place after serious incidents), they all said that they felt supported and knew where to access support services.

Good practice

82. Mr Lightfoot's cellmate was offered good support after Mr Lightfoot's death.

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

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T I 020 7633 4100