Her Majesty's Coroner
Staffordshire (South) Coroner's Jurisdiction

Private and Confidential
[redacted]
Head of Healthcare
HMP Dovegate
Marchington
Uttoxeter Staffs
ST14 8XR

Please note that our reference must be included on all correspondence

Date: 14 January 2020
Our ref: AAH/EAS 149963
Your ref: ---

Dear [redacted]

Andrew A Haigh
Senior Coroner

Margaret J Jones
Richard G M Hughes
Emma Serrano
Heath Westerman
Ian S Smith
Assistant Coroners

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Re: Marlon Roy WATSON (deceased)

I make this report under paragraph 7 Schedule 5 of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

On **1st October 2018** I commenced an investigation into the death of **Marlon Roy WATSON** aged **32**. The investigation concluded at the end of the inquest on **8th January 2020**. The conclusion of the inquest was **Suicide by hanging.**

The jury's findings were: A. Basic circumstances: Marlon Roy Watson was a serving prisoner at HMP Dovegate when he died by hanging in his cell on 29th September 2018.
B. Probable causative factors : Breakdown of relationship with partner, bullying, debt, poor mental health and use of illicit substances. Combined effect of this being too much pressure.
C. Possible causative factors: The mental health team's reliance on self-referral and prison mentors rather than a pro-active approach. Admin errors leading to missed opportunity for support and unanswered/unacknowledged phone calls from sister. Failure for different health care teams to have access to relevant patient information.

During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths may occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The **MATTER OF CONCERN** is as follows. –

1. **At the inquest there was a concern that members of healthcare staff at HMP Dovegate do not have a full and proper**

understanding of the ACCT process. I would appreciate reassurance that appropriate initial training and refresher training takes place and that (if possible) this is audited.

In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action. You are under a duty to respond to this report within 56 days of the date of this report, namely by **9.3.2020** . I may extend the period if required to do so.

Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.

I have sent a copy of my report to the Chief Coroner and to the following other persons

- **The Chief Coroner**
- **Solicitors acting for Care UK, Serco and the family**
- **Prisons and Probation Ombudsman**
- **Independent Monitoring Board**

I am also under a duty to send the Chief Coroner and others interested a copy of your response.

The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me at the time of your response about the release or the publication of your response by the Chief Coroner.

Yours sincerely

Andrew A Haigh
HM Senior Coroner
Staffordshire (South)