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

Date: 11 February 2021

Case: [redacted]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: [redacted] Director, HMP Dovegate, Marchington, Uttoxeter, Staffordshire, ST14 8XR

CORONER'S LEGAL POWERS

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.

http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7

http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

INVESTIGATION and INQUEST

On 26 November 2019 I commenced an investigation into the death of Michael Richie DOBSON ('Mike'). The investigation concluded at the end of the inquest on 9 February 2021. The conclusion of the inquest was suicide with the cause of death being hanging.

CIRCUMSTANCES OF THE DEATH

Mike applied a ligature to himself using a piece of linen/sheet through a hole in the ceiling and hanged himself. This hanging occurred on 24.11.2019 at an approximate time between 19.00 and 19.25. Death was pronounced at Queen's Hospital Bruton on 22.25 on 24.11.2019.

Probably causative factors: Mike had long standing poor mental health issues. There were also issues around illicit drug use. Mike had fractured family relationships. Mike had difficulties in establishing and engaging with relationships and the support offered to him.

Possibly causative factors: A lack of central base of information accessible to all relevant staff with useable information.

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CORONER'S CONCERNS

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

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

The hanging incident occurred after prison lockdown. Shortly prior to this the electricity supply for the sockets in the cell had tripped. Mike had used his cell bell to call a prison officer and he was told it would be sorted out but probably not until the next day. The inquest also heard that in some cases (not Mike's) that cell lights will trip and this tends to take out four cells. It is also possible that other damage may be caused to cells. I am aware that there are very limited staff and security concerns following lockdown. If however prisoners become aware that remedial action may not take place until the following day this does provide a potential (either deliberate or accidental) for prisoners to harm themselves. I wonder if it is possible for some form of basic maintenance to be available during lockdown hours. If this concern appears more to be a national one rather than a local one then please feel free to pass it on to whoever it is appropriate to deal with it.

ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action. Otherwise you should explain why no action is proposed.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely **by 8 April 2021.**

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

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons

HCB Solicitors – representing the family, DWF Law – representing Serco, Capsticks – representing Midlands Partnership Foundation Trust and Hill Dickinson Solicitors - representing Practice Plus. I have also sent it to Prison and Probations Ombudsman and the Independent Monitoring Board.

I am also under a duty to send the Chief Coroner 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, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.

11 February 2021

Andrew Haigh Senior Coroner for Staffordshire South.

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