I am submitting details of this case for inclusion in the Review. The report is in fact written as an Article for Inquest Law and yet to be published in the summer edition, but hopefully provides a relevant summary for you to consider. The case highlights a failure to follow ACCT procedures and mandatory Prison Service Orders. I will be happy to provide whatever further information may be required, and Kieron's mother would also very much wish to be involved.

Yours sincerely, Ruth Bundey

Harrison Bundey solicitors.

Kieron Dowdall

MANDATORY INSTRUCTIONS FOR CARING FOR A VULNERABLE PRISONER IGNORED.

By Ruth Bundey of Harrison Bundey Solicitors

Name of deceased: Kieron Paul Dowdall

Place of death: HMP Stafford

Date of death: 27th January 2012

Date of inquest 24th – 27th February 2014

Cororoner: HM Senior Coroner for Staffordshire (South) Coroners Jurisdiction, Andrew A Haigh.

Solicitor and Advocate at inquest: Ruth Bundey, Harrison Bundey Solicitors

Other interested Parties represented: Ministry of Justice, Staffordshire County Council for the Partnership Health Trust.

Verdict: Suicide with narrative

Background:

Kieron Dowdall died at Stafford Prison when he was 24 years of age. He had been sentenced in January 2007 to an indeterminate sentence with a tariff to serve at least 3½ years. His tariff date had ended in October 2009 given that he had been remanded in custody prior to

his sentence. He had self-harmed by trying to strangle himself prior to his court hearing through fear and uncertainty as to what would happen to him.

Until he was 21 he spent time in Young Offender Institutions and then transferred to Stafford Prison and from there, in October 2010, to North Sea Camp, an open prison near Boston, Lincolnshire. There he worked 5 days a week outside prison at a Great Dane Sanctuary and had various periods of day release and home leave. In September 2011 he breached a geographical condition of his release on temporary leave and had his privileges withdrawn for 3 months, but these were re-instated by January 2012 when he was visited by his mother, his mother's partner, and pen-pal girlfriend, and allowed day release on successive days to the family's caravan.

Tensions arose during this period due to Kieron feeling that he was being pulled in different directions, and he became upset, with the result that on Monday morning 9th January 2012 he absconded from North Sea Camp saying that he wanted to take his own life. He was persuaded by his Family and a Governor to return to the prison within a matter of hours but due to his assessed vulnerability and being a danger to himself, he was placed on an ACCT (Assessment Care in Custody and Teamwork) and transferred to HM Prison Lincoln, as he could not be safely observed and monitored in open conditions. His ACCT, however, said that he needed to be returned to North Sea Camp as soon as possible due to his good progress there.

Within 24 hours at Lincoln he had self-harmed by making serious lacerations to his wrist and had to be taken to hospital. He said that he wanted to end it all and could not at that stage give any assurance that he would not make a further attempt on his life. Two "suicide" notes were found in his cell.

Following this, he was closely monitored and numerous statements within his ACCT documents refer to the fact that he had gone to Lincoln for a 10 day lie down and would return to North Sea Camp at the end of that period, on Thursday 19th January. His "Care Map" within the ACCT set out the details of support that would be made available to him back at North Sea Camp working towards release. His mood lifted and his ACCT was closed on 17th January but with a caveat that confirmed the expectation that he would return to North Sea Camp two days later, adding "if that does not happen, we will re-evaluate."

On 19th January Kieron did not move and expressed surprise and anxiety. On 20th January he was collected from his cell and only then told that he was being moved to Stafford, the Category C establishment where he had been until October 2010.

The relevant Prison Service Order specified that any transfer of a prisoner on an ACCT or in the post-closure phase of an ACCT (as Kieron was) must have his case discussed with the receiving establishment and a full case review held with the Prisoner. Neither of these things happened. The Safer Custody and Offender Management Unit at Lincoln had no idea that he was moving to Stafford until he had arrived there, and Stafford had no idea either until they saw him. The Senior Officer at Stafford Reception on the 20th January immediately noticed that although Kieron had been on an ACCT until 17th January, and had a post-closure review due (on 24th January) no ACCT documents had accompanied him to Stafford, again a clear breach of the mandatory requirements of the Prison Service Order. She asked for the ACCT document to be both faxed and posted to Stafford Prison.

The Inquest:

Evidence was called at the inquest into Kieron's death commencing with his arrival at Stafford Prison. It emerged that the faxed ACCT, when it arrived later on 20th January, had simply been filed away and that when the top copy was sent recorded delivery and arrived on 24th January, it was placed in a tray for the Safer Custody Co-ordinator who was not present and who did not look at the document until after Kieron's death.

Health Care and Prison Staff at Stafford therefore never saw this document or its alarming contents, and the post-closure review set for the 24th January never took place. The Senior Officer in charge on 20th January for the Wing to which Kieron went told the inquest that had he known of the contents of the ACCT, and the self-harm at Lincoln whilst on the ACCT, he would have re-opened it and put in place safeguards and observations. Health Care Staff, and other Discipline Staff, whilst knowing that an ACCT post-closure review was due did nothing to chase up the missing documentation internally or with Lincoln.

According to Prisoner witnesses, and Staff, Kieron grew obsessed with his status and the uncertainty of his position, not knowing whether he remained a Category D inmate, all be it in a Category C establishment, or not, unclear as to why he was in Stafford at all and why he had not returned to North Sea Camp. On 23rd January 2012 he phoned his mother on five

occasions, expressing his anguish at the prospect of doing further years in prison just as he had thought he was nearing release, telling her that he didn't have it in him to carry on and it was "game over".

The following day, highly alarmed by these phone calls, his mother made numerous calls herself to various Agencies and to the Lawyer who had dealt with Kieron's last hearing before the Parole Board. She and her partner then phoned Stafford Prison on Wednesday 25th January, expressing their great concern about Kieron's welfare and asking to speak to various specified individuals including the Safer Custody Co-ordinator, individuals who were known to Kieron's mother from his previous time at Stafford Prison. They were told that no one was available to speak to them and they should put their concerns in writing.

On Thursday 26th January Kieron's cell mate was moved to another Wing. The Senior Officer who had had concerns about Kieron the previous Friday when he arrived had deliberately put him in with a cell mate as a safeguard and for company, and had been additionally concerned when Kieron told him that he "wouldn't want to be on his own for too long." Nobody realised the potential risk of Kieron remaining in a cell in sole occupancy. That same day he visited a nurse in Health Care. She noted, as others had, that his post-closure review in respect of his previous ACCT had not been done, but did nothing about this and indeed added an exclamation mark to her notes. She recorded that Kieron told her he was "struggling daily" and felt he was having a breakdown. She did not communicate this to Wing Staff.

That evening Kieron again expressed to another Prisoner his anguish at the uncertain situation in which he found himself. He was locked up alone in his cell at 8pm and the following morning just after 6am was discovered self-suspended, paramedics estimating that he could have been dead for some six hours.

The Jury's Conclusions;

The Coroner summed up the evidence faultlessly to the Jury, dealing with the evidence on an issue by issue basis, rather than simply reminding them, Witness by Witness, of what had been said.

The Jury retired for two hours. They concluded that Kieron took his own life intending to do so, and added:

> “The Jury considers that breakdown in communication between Lincoln, North Sea Camp, and Stafford Prisons contributed to Kieron’s death.
>
> The Jury also considers that the way in which information was or was not processed or acted upon between the prison departments and not least the lack of communication with Kieron, also contributed to his death.”

Kieron’s mother, step-father and de facto grandparents were immensely reassured by the Jury’s conclusions and extremely grateful for the fair and clear way in which the Coroner had directed them. The attribution of responsibility to all three prison establishments who dealt with Kieron in the last three weeks of his life has helped them to move on and pick up their own lives again.

As Kieron was only 24 when he died, his case will fall to be included within the Independent Review of deaths of young people between the ages of 18 and 24 set up by the Ministry of Justice. It is hoped that the wider issues of following to the letter the mandatory provisions of the ACCT process will be, once again, emphasised and re-enforced.