Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Andrew Hill, a prisoner at HMP Holme House, on 3 February 2022

A report by the Prisons and Probation Ombudsman

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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.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Andrew Hill died on 3 February 2022 at HMP Holme House, when he was found hanged in his cell. He was 21 years old. I offer my condolences to Mr Hill's family and friends.

Mr Hill was an emotionally damaged and impulsive young man. He had a high number of risk factors for suicide and self-harm that meant his risk fluctuated according to context but was never absent. His parents died when he was a teenager and his only regular family contact at the time of his death was with his girlfriend.

Mr Hill was found hanged in his cell less than 90 minutes after he had said he would kill himself during a row with his girlfriend over his drug debt. The investigation found no evidence that Mr Hill was at increased or imminent risk of suicide and self-harm before this row and therefore I do not consider that staff at Holme House could reasonably have predicted his actions or prevented his death.

Mr Hill's telephone calls to his girlfriend revealed that he was increasingly anxious about threats from two prisoners over payment of his debt. Despite regular keyworker sessions, Mr Hill did not tell staff that he was being threatened until 2 February, the day before he died. I consider that staff responded swiftly and appropriately to manage the situation based on the information Mr Hill gave them.

The investigation found a number of deficiencies in suicide and self-harm monitoring procedures applied to Mr Hill at HMP Durham in November 2021. While I cannot say that these directly contributed to Mr Hill's death, I have highlighted them as learning points for the future. I make another recommendation to Holme House to ensure that all information about risk is captured via the information reporting system.

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 2025**

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Summary

Events

1. On 24 June 2021, Mr Hill was remanded in prison custody by Middlesbrough Magistrates Court for driving a vehicle dangerously and conspiracy to pervert the course of justice. He was taken to HMP Durham the same day. Mr Hill had outstanding charges relating to an assault on his girlfriend. It was not his first time in custody, but it was his first time in an adult prison.

2. On 3 November, a nurse began Prison Service suicide and self-harm monitoring procedures (known as ACCT) after Mr Hill said that he was grieving the death of his mother and thought about ending his life "every few days, sometimes every day". ACCT procedures were stopped at the first review the next day.

3. On 14 December, Mr Hill was sentenced to 14 months in prison for driving a vehicle dangerously and transferred to HMP Holme House on 17 December. He was offered psychological well-being support for his bereavement issues but declined the service.

4. Due to his age, Mr Hill had regular keyworker sessions at Holme House and appeared fine. He told staff that he and his girlfriend argued frequently but did not appear distressed by this.

5. Mr Hill's prisoner telephone (PIN) calls from 26 January onwards revealed that he was under pressure to pay a drug debt and that his girlfriend was paying other prisoners for him, but staff were not aware of this at the time.

6. On 2 February, Mr Hill told an officer that he was being threatened by unnamed prisoners and he was worried that his cellmate would attack him on their behalf. The officer immediately moved Mr Hill's cellmate to another cell and the wing manager agreed he would stay locked in his cell until he could move to another houseblock.

7. On 3 February, Mr Hill told his girlfriend that he had arranged to pay his debt from his prison shop orders, however his telephone calls indicated he was still receiving threats. Mr Hill and his girlfriend argued about his debt, she appeared to end their relationship and Mr Hill told her he would "do himself later".

8. At 5.33pm, an officer found Mr Hill hanged in his cell. Staff began cardio-pulmonary resuscitation (CPR) promptly and efficiently. Prison nurses and paramedics attended quickly but Mr Hill was declared dead at 6.09pm.

Findings

9. Mr Hill had a high number of risk factors that indicated he was at risk of suicide and self-harm, including attempted suicide, depression, anxiety, substance misuse and lack of family support. His emotional damage and impulsivity meant that his risk fluctuated according to context but was never absent.

10. We identified a number of deficiencies in the ACCT process at Durham. These were not directly connected to Mr Hill's death but provide good learning points for the prison.

11. We found no evidence that Mr Hill was at increased or imminent risk of suicide and self-harm before the telephone calls with his girlfriend less than 90 minutes before he was found hanged. We do not therefore consider that staff at Holme House could reasonably have predicted his actions or prevented his death.

12. We consider that staff responded swiftly and appropriately to manage the threat to Mr Hill based on the information he gave them on 2 February. The officer in receipt of the information did not complete an information report (IR) as she should have done, although this did not change the outcome for Mr Hill.

13. Since Mr Hill's death, the Rethink Mental Illness (a mental health charity) team and safer custody lead have developed a process to ensure that Rethink are informed when prisoners are rejected for release on Home Detention Curfew (HDC). Although Mr Hill's application for HDC was not directly connected to his death, this is good practice.

Recommendations

For HMP Durham

- The Governor of HMP Durham should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines. In particular, staff should:
  - complete the immediate action plan within the set timeframe;
  - make a considered, objective evaluation of all risk factors when assessing the risk of suicide and self-harm;
  - set effective caremap objectives which are specific, time-bound and meaningful, aimed at reducing risk and updated at each case review;
  - vary times of ACCT checks, while remaining within set observation periods, to avoid prisoners being able to predict when they will be checked; and
  - hold a post-closure review as soon as possible after the seven day post-closure monitoring period.

For HMP Holme House

- The Governor of Holme House should remind all staff of the importance of completing information reports (IRs) when they receive information about threats of violence and bullying.

The Investigation Process

14. The investigator issued notices to staff and prisoners at HMP Holme House informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

15. The investigator obtained copies of relevant extracts from Mr Hill's prison and medical records. She watched CCTV from 3 February, listened to radio transmissions and to recordings of Mr Hill's prison telephone calls between 26 January and 3 February. After reading the evidence, she requested CCTV footage from 1 and 2 February, but this was not available. She also obtained records from North East Ambulance Service and listened to the 999 call from 3 February.

16. The investigator interviewed six members of staff and four prisoners in person and two members of staff by telephone, in March and April 2022.

17. NHS England commissioned a clinical reviewer to review Mr Hill's clinical care at the prison. The investigator and clinical reviewer interviewed a further two members of staff by telephone in April 2022.

18. We informed HM Coroner for Teesside of the investigation. At the time of writing, we have not received a copy of the post-mortem report. We have sent the Coroner a copy of this report.

19. Our family liaison officer contacted Mr Hill's next of kin, to explain the investigation and to ask if they had any matters they wanted the investigation to consider. Mr Hill's next of kin asked us for details about when Mr Hill was managed under Prison Service suicide and self-harm monitoring procedures. We have sent them a copy of this report.

Background Information

HMP Holme House

20. HMP Holme House is a category C training prison holding over 1200 men. Spectrum Community Health CIC provides primary care health services at the prison. Tees, Esk and Wear Valleys NHS Foundation Trust provides mental health services and Rethink Mental Illness (a mental health charity) provides psychological well-being services.

HM Inspectorate of Prisons

21. The most recent inspection of HMP Holme House was in February and March 2020, before the COVID-19 pandemic. Inspectors found that the prison was not safe enough and, although overall levels of violence were consistent with similar prisons, the strategy to reduce violence needed to be more robust.

22. Significant investment, and a coordinated strategy through the Drug Recovery Prison (DRP) Programme, had delivered some impressive reductions in the availability of illicit substances. The gathering of security information and management of intelligence were good. The security team was supported by a regional intelligence unit (RIU), which had oversight of all prisons in the Tees and Wear area and was staffed seven days a week. Well attended security-led meetings made use of a comprehensive intelligence assessment produced by the RIU to respond to emerging threats, identify new risks and set relevant security objectives.

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, published in August 2021 for the year to December 2020, the IMB noted that the COVID-19 pandemic had meant they were unable to fulfil their statutory role for most of the reporting year. The DRP continued to be delivered, although drugs were still a significant problem in the prison.

Previous deaths at HMP Holme House

24. Mr Hill was the thirteenth prisoner to die at Holme House since February 2020. Of the previous deaths, eight were from natural causes, two are awaiting classification, and two were self-inflicted. There has been one death since, from natural causes.

25. Although there were indications in one of the previous self-inflicted deaths that the prisoner was being threatened, there are no direct similarities between that death and Mr Hill's death.

Assessment, Care in Custody and Teamwork (ACCT)

26. 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.

27. 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 multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap identifying support actions is put in place. The ACCT plan should not be closed until all the support actions on the caremap have been completed.

Key Events

28. Mr Andrew Hill had a history of substance misuse, suicidal thoughts, attempted suicide, anxiety and depression. His OASys report (a risk assessment completed by his offender manager) described him as a complex, emotionally damaged, and impulsive young man. Mr Hill's parents both died while he was still a teenager. He was prescribed venlafaxine (an anti-depressant also used to treat anxiety).

HMP Durham 24 June – 17 December 2021

29. On 24 June 2021, Mr Hill was remanded in prison custody by Middlesbrough Magistrates Court for driving a vehicle dangerously and conspiracy to pervert the course of justice. He was taken to HMP Durham the same day. Mr Hill had outstanding charges relating to an assault on his girlfriend. It was not his first time in custody, but it was his first time in an adult prison.

30. On 9 August, Mr Hill was referred for bereavement counselling about the death of his mother in 2019. On 1 October, Mr Hill spoke to a health support worker about the same issue. She noted that he had been referred but not seen and requested that he be seen as soon as possible.

31. On 3 November, Mr Hill asked to speak to a nurse in passing. Mr Hill said that he had been waiting to speak to the mental health team for several months and was feeling anxious and depressed. Mr Hill said that he was grieving the death of his mother in December 2019 and thought about ending his life "every few days, sometimes every day". He said he had thought about "stringing myself up" a few days previously but had not done so because he was "too tall to do it from the bed".

32. The nurse began Prison Service suicide and self-harm monitoring procedures (known as ACCT). Mr Hill told an ACCT Assessor that he was struggling with the sudden death of his mother. He said that he used drugs outside prison to numb his grief and was feeling overwhelmed now their effects had receded. He also said he did not think his medication was helping his anxiety. He had tried to hang himself seven months previously, but his girlfriend had stopped him.

33. Two actions were added to Mr Hill's care support plan at the first ACCT case review the next day – he was to be referred to the GP for a medication review and referred, a third time, for bereavement counselling. These actions were marked as completed and Mr Hill's ACCT was closed. Although both referrals were made, Mr Hill had neither a medication review nor bereavement counselling in Durham. (The investigator established that the bereavement counsellor had left her post in September 2021 and the vacancy was not filled until January 2022 after Mr Hill had left Durham.) Mr Hill did not have an ACCT post-closure review as he should have done.

34. On 14 December, Mr Hill was sentenced to 14 months in prison for driving a vehicle dangerously. He was found not guilty of perverting the course of justice.

HMP Holme House 17 December 2021 – 1 February 2022

35. On 17 December, Mr Hill transferred to HMP Holme House. He was within the six-week post-closure phase of ACCT monitoring, but this was neither flagged by Durham safer custody team nor identified at Holme House.

36. Mr Hill was identified as a priority prisoner for keyworker sessions due to his age. He had his first keyworker session on 20 December and appeared fine. He said he had applied for release on HDC and was hoping to be released in January.

37. Also, on 20 December, a worker from the Durham Rethink team, telephoned the Holme House Rethink counsellor and told her that Mr Hill was on the waiting list for bereavement counselling and might benefit from a welfare check. The counsellor and a Rethink psychological wellbeing practitioner (PWP) visited Mr Hill the next day, but Mr Hill declined any support. The PWP said that Mr Hill was very focussed on the fact that he was eligible for release on HDC in January. She offered to contact a community group for bereavement support on his release, but Mr Hill declined this offer as well.

38. Mr Hill had keyworker sessions on 23 and 30 December and again appeared to be fine. On 31 December, he moved to Houseblock 1 after 14 days quarantine under measures to reduce the spread of COVID-19 in prisons. On 5 January 2022, he had another keyworker session and appeared well. He said he was keeping in regular contact with his girlfriend and felt settled on Houseblock 1.

39. On 9 January 2022, Mr Hill's application for release on HDC was denied because his release address was deemed unsuitable.

40. On 13 January, Mr Hill had a keyworker session with an officer. The officer said Mr Hill appeared fine. He was in regular contact with his girlfriend and was still hoping for release on HDC to a different address.

41. Mr Hill had a second keyworker session with the officer on 17 January. The officer said Mr Hill told him that he had cut ties with his girlfriend because arguing with her was stressful. The officer said that Mr Hill gave him the impression that arguing with his girlfriend was not unusual and he did not appear to be distressed about cutting ties with her. Mr Hill said that he found the increased time in cell due to COVID-19 lockdown very difficult and the stress of arguments with his girlfriend made things worse. The officer interpreted Mr Hill's decision to break off contact with his girlfriend as a positive move to reduce his stress.

42. On 25 January, a prison GP spoke to Mr Hill by telephone. The main reason for the consultation was ongoing assessment of a bowel issue. Mr Hill also said he did not think his anti-depressant was helping him enough. The GP agreed to increase his dose of venlafaxine.

43. The investigator listened to Mr Hill's prisoner telephone calls (PIN calls) from 26 January – 3 February. On 26 January, Mr Hill said he had told another prisoner that the "payment" would go through in a couple of days.

44. On 27 January, an officer had a keyworker session with Mr Hill. Mr Hill said that he had no issues. He was aware of how to access video-link visits but only used them

sometimes because he tended to argue with his girlfriend, and it caused him unnecessary stress.

45. Also, on 27 January, the prison security department received information from the Financial Intelligence Unit (FIU) that a woman had tried three times to send money to another prisoner's account. They did not know at this stage that the woman was Mr Hill's girlfriend, and the information was not immediately linked to his security record.

46. During the course of 16 telephone calls that day, Mr Hill asked his girlfriend whether she had put some money in another prisoner's account. She tried to make the payment again, but it was rejected.

47. Mr Hill made 14 telephone calls to his girlfriend on 29 January, and it is evident that her further attempts to pay money to another prisoner were declined.

48. On 31 January, Mr Hill had a keyworker session with an officer. She said she spoke to Mr Hill outside his cell during the hour that prisoners were let out of their cells. She said that Mr Hill seemed in good spirits and there was no indication that he was anxious about other prisoners or being out of his cell.

49. Mr Hill told her he was in regular contact with his girlfriend and was looking forward to having a proper visit with her. He asked her about his applications for release on HDC but did not seem to be distressed by not having received a decision.

50. Mr Hill spoke to his girlfriend during the evening and appeared to be low in spirits. His girlfriend told him he sounded suicidal. He denied it but she told him she knew what he was like and not to "do anything stupid".

51. On 1 February, the FIU identified the woman attempting to pay money into another prisoner's account as Mr Hill's girlfriend. Mr Hill's girlfriend was noted to have paid money into the accounts of three other prisoners. An information report (IR) was added to Mr Hill's security record.

52. At 5.02pm, Mr Hill rang his girlfriend and told her he was going to move to a different wing because Mr Y (a prisoner identified by Holme House but not named for security reasons) was trying to collect money for Mr X (a prisoner identified by Holme House but not named for security reasons) and was going to stab him. He said he would stay behind his door until he could move. There is no evidence that Mr Hill had spoken to staff about this.

53. At 8.34pm, Mr Hill asked his girlfriend to pay £50.00 to a different prisoner (not named for security reasons) and gave her the account details. Mr Hill said he was worried about the threats he had received, and his girlfriend tried to reassure him.

2 February 2022

54. At about 8.30am, Mr Hill told Officer A that he was under threat from other prisoners because of the nature of his crime and there was a price on his head. He said he was worried that his cellmate would take the price and seek to harm him. He said he might have to hurt his cellmate or take him hostage before his cellmate hurt him.

He wanted to move to a different houseblock and to stay behind his door until he could do so.

55. Officer A said Mr Hill seemed genuinely terrified that his cellmate would attack him. She said Mr Hill was adamant that he would not tell her who had threatened him.

56. Officer A spoke to a Custodial Manager (CM) and they decided the best option in the short term was to move Mr Hill's cellmate to another cell. She agreed Mr Hill would stay behind his door until he could be moved to a different houseblock. The officer said Mr Hill appeared pleased with this outcome. She said she had no concerns that Mr Hill was a threat to himself and decided not to begin ACCT procedures.

57. Officer A did not submit a security report (IR) about the incident. She said that she forgot because she was busy arranging the cellmate's cell move and could not leave her role on the landing.

58. The cellmate said he shared a cell with Mr Hill from about 14 January. He said Mr Hill was usually upbeat and the only time he had seen Mr Hill down was after he had argued with his girlfriend. He knew Mr Hill's parents were dead and that his girlfriend was the only person he had outside prison. Every time Mr Hill argued with his girlfriend, he told him that he had nothing left. The cellmate said the arguments were usually resolved in a couple of days and Mr Hill would be upbeat again.

59. The cellmate said he got on OK with Mr Hill. After Mr Hill died, he heard rumours that Mr Hill had been in debt, but he was certain Mr Hill was not on drugs when they shared a cell. He did not think Mr Hill's debt had been a big issue for him. He thought that if someone had threatened Mr Hill, he would not have had an issue fighting them or standing up for himself.

60. The cellmate said his cell move came as a surprise to him. After his morning cleaning duties an officer told him he had to move cell but did not say why. He said he thought Mr Hill might have been trying to get a single cell. He did not think Mr Hill would have hurt him as they got along well.

61. Mr Hill telephoned his girlfriend eight times during the afternoon and evening. At 1.56pm, he told her he was not OK. He seemed worried that he had not been moved to another wing. At 4.02pm, he told her that the money had not gone through and asked her to get her mother to try. Mr Hill said he was going to see Mr Y to try and "sort it out". He appeared stressed by the situation and was hungry because he had not gone out for his teatime meal. At 6.01pm, Mr Hill told his girlfriend that Mr X had been trying to lure him out of his cell so that Mr Y could hurt him. He said, "they will get me".

Events of 3 February

62. CCTV showed Mr Hill left his cell at 8.29am. He mixed with other prisoners, including his cellmate, and did not appear to be distressed or under any form of duress. At 9.19am, he had a shower and spent a couple of minutes talking and laughing with his neighbour before being locked back in his cell at 9.33am.

63. The cellmate said that Mr Hill had seemed alright when he spoke to him. They had a conversation about a TV show coming on that evening that they had both looked forward to watching. He asked Mr Hill about his move from their cell and Mr Hill told him that it was something to do with security information received.

64. At 11.25am, Mr Hill spoke to his girlfriend on the phone. He said he was not OK and had been talking to Mr X about Mr Y. Mr Y wanted the money and an apology or "if not I'm getting it". Mr Hill said he was going to apologise to Mr Y. (CCTV did not show Mr X speaking to Mr Hill during the period he was out of his cell, however, Mr Hill spent some minutes out of view on the landing below and in the shower.)

65. At 11.39am, Mr Hill collected his lunch and left it in his cell while he went upstairs at 11.42am for just over a minute and a half (Mr X and Mr Y shared a cell upstairs from Mr Hill). He was locked back in his cell at 11.44am.

66. At 12.24pm, Mr Hill spoke to his girlfriend again. Mr Hill said that he had arranged to pay his debt with two different prison shop orders worth £15.00 each.

67. Mr Hill telephoned his girlfriend again at 12.57pm for 12 minutes, but neither the investigator nor the prison was able to play the call.

68. Three prisoners stood outside Mr Hill's cell at different times between 10.24am and 3.20pm. The angle of the camera means it is not possible to be certain whether the prisoners are at Mr Hill's door or that of his neighbours.

69. The investigator spoke to all three prisoners, but none of them could remember any significant conversation with Mr Hill that day.

70. At 3.22pm, Mr Hill asked his girlfriend if she was messaging Mr X's brother because Mr X had told him she was. Mr Hill's girlfriend denied sending any messages. Mr Hill said Mr X had threatened to burn her house down. He said he was going to have to attack Mr X with a padlock in a sock to stop him threatening him. Mr Hill said his head was "done in" and he needed to move off the wing.

71. At 3.59pm, Mr Hill and his girlfriend discussed his debt and what to do about Mr X. Mr Hill's girlfriend asked him what his debt related to, and Mr Hill said it was for vapes. Mr Hill's girlfriend said she did not believe him because vapes were not that expensive. An argument developed with Mr Hill's girlfriend insisting he tell her the truth about his debt. Eventually he confessed his debt was for "subbies" (Subutex – a semi-synthetic opioid). His girlfriend said, "fuck off you little smackhead" and put the phone down.

72. Mr Hill called his girlfriend back at 4.09pm. She was still very angry and told him she would not pay his debt and would block his number. Mr Hill said, "I'll do myself tonight" and she said she did not care and put the phone down.

Emergency response

73. At 5.32pm, Officer B began unlocking the cells on Mr Hill's side of B2 landing. CCTV showed she arrived at Mr Hill's cell at 5.33pm. She opened the observation panel and saw Mr Hill hanged from the ceiling light by a sheet. She said Mr Hill was fully suspended with his legs bent and his toes touching the floor. She shouted

"staff" and then immediately radioed a medical emergency code blue to indicate a prisoner not breathing. The control room immediately called an ambulance, and one was dispatched with the highest priority response.

74. Officer C was on the opposite side of the landing unlocking prisoners. He ran over and immediately unlocked Mr Hill's door. He held Mr Hill up and Officer B used her cut-down tool (known as a fish knife) to cut the sheet from Mr Hill's neck. The officers laid Mr Hill on the cell floor.

75. Officer D was on B3 landing when he heard Officer B shout for staff. He ran immediately to Mr Hill's cell and arrived as Officer C opened the door. He helped Officer C lift Mr Hill and then started chest compressions (CPR) as soon as Mr Hill was put on the floor.

76. Officer D said that Mr Hill was white and lifeless. His eyes were staring straight ahead and not moving. Mr Hill was not breathing or moving, and his presentation did not change during chest compressions. He said although he thought Mr Hill was already dead, he was not in rigor mortis.

77. CCTV showed a nurse and a healthcare support worker arrived at Mr Hill's cell with the emergency medical equipment at 5.35pm. The nurse said there were a number of staff in the cell and an officer was correctly performing chest compressions. A defibrillator and oxygen had already been brought from the Houseblock 1 office. The nurse said all the equipment was in good working order.

78. The nurse said Mr Hill had a deep ligature mark on his neck. He showed no respiratory effort, no rise and fall of his chest, his pupils were fixed and dilated but he was still warm and there was no sign of cyanosis or any of the signs unequivocally associated with death.

79. Officer D carried on with chest compressions while the nurse attached the defibrillator and set up the oxygen and bag and mask. The healthcare support worker managed Mr Hill's airway initially and then the nurse, the healthcare support worker and another nurse rotated chest compressions and airway management until ambulance paramedics arrived and took over.

80. CCTV showed two paramedics arrived at the cell at 5.44pm. They inserted a more secure airway and gave Mr Hill adrenaline. At 6.09pm, paramedics recorded that Mr Hill had died.

Intelligence received after Mr Hill's death

81. Mr Hill's girlfriend told the prison family liaison officers that Mr X and Mr Y had bullied Mr Hill by encouraging him to take illegal substances that they knew he could not afford, in order to get him into debt.

82. Security staff subsequently listened to PIN calls made by the two prisoners. In a call made at 3.01pm on 3 February, Mr X said that he had prevented Mr Y from hitting Mr Hill, but Mr Hill had been "cheeky" when he saw him that morning at his door. Mr X threatened to hit Mr Hill and have him "done in". He also said he had gone to Mr Hill's door before teatime and told him to enjoy his meal because he had

asked the servery workers to do something to his food. (CCTV showed Mr X did not go to Mr Hill's cell at this time.)

Contact with Mr Hill's family

83. The prison appointed two family liaison officers and they drove to Mr Hill's girlfriend's house that evening to break the news of his death in person. When they arrived, they discovered that another prisoner on Mr Hill's wing had already telephoned a friend, who had told Mr Hill's family. The family liaison officers remained in contact with Mr Hill's next of kin and returned Mr Hill's property to them.

84. The prison contributed to the cost of Mr Hill's funeral in line with national guidance.

85. Staff spoke to the prisoner responsible for indirectly contacting Mr Hill's family about the upset his actions had caused the next of kin.

Support for prisoners and staff

86. After Mr Hill's death, senior management debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The trauma risk management (TRiM) team and staff care team also offered support.

87. The prison posted notices informing other prisoners of Mr Hill'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 Mr Hill's death. The cellmate said he was upset by Mr Hill's death and had received very good support from one officer in particular. The investigator made the prison aware of the officer's good practice.

Post-mortem report

88. We have not received the post-mortem report or toxicology reports at the time of writing this report. We have not found any evidence that Mr Hill was under the influence of illicit substances at the time of his death.

Inquest

89. The Coroner's Inquest held in May 2025 gave the medical cause of death as pressure on the neck due to hanging. The jury listed Mr Hill's fear of violence due to debts owed, the breakdown of his only significant relationship and that he was not asked further questions about his mental health and fear of assault after his cellmate moved out on 2 February as contributory factors.

Findings

ACCT procedures at Durham

90. We identified a number of deficiencies in the ACCT process at Durham. While we cannot say that these directly contributed to Mr Hill's death, our investigations seek to learn lessons for the future, and we consider that there is useful learning in this case. Mr Hill had a high number of risk factors that indicated he was at risk of suicide and self-harm, including attempted suicide, depression, anxiety, substance misuse and lack of family support. His emotional damage and impulsivity meant that his risk fluctuated according to context but was never absent.

91. Mr Hill's ACCT concern form included significant information about his current risk. In particular, he thought about suicide, "every few days, sometimes every day", and had considered the means to do it. Mr Hill's ACCT assessment further identified that Mr Hill felt depressed and overwhelmed with grief for his mother. We consider that these factors alone should have caused concern. Despite this evidence of risk, Mr Hill's ACCT document was closed at the first case review.

92. Staff judgement is fundamental to the ACCT system. The system relies on staff using their experience and skills, as well as local and national assessment tools, to determine risk. While a prisoner's presentation is obviously important and reveals something of their level of risk, it is only one piece of evidence in judging risk. Staff should make a considered, objective evaluation of all risk factors when assessing the risk of suicide and self-harm. We consider that there was too much reliance on what Mr Hill said at his first case review, rather than an objective evaluation of all his risk factors.

93. The two care plan support actions were weak and did not effectively address Mr Hill's issues. Referrals for a medication review and bereavement counselling were the first step to addressing Mr Hill's depression and grief but they did not result in any action or support for Mr Hill.

94. Ongoing monitoring should have revealed that there was no bereavement counsellor in place at Durham at the time and allowed for alternatives to be explored. It should also have resulted in Mr Hill's medication being reviewed sooner than 25 January, nine days before he died. (We note that the Holme House GP immediately increased Mr Hill's dose indicating that the previous dose was not dealing effectively with his depression.)

95. There were also a number of procedural weaknesses in Mr Hill's ACCT, including:

- The immediate action plan was not completed within the timeframe.
- The key information, resident contribution and external sources of support sections were not completed.
- Observations were at predictable intervals.
- There was no post-closure review and no handover to Holme House despite Mr Hill transferring there within the six week period following closure when the ACCT might be re-opened.

96. The Early Learning Review (ELR) conducted by HMPPS North East Area Safer Custody team identified the deficiencies in the ACCT process at Durham and communicated them to the Head of Safer Custody on 16 February. The investigator contacted Durham to find out what action had been taken. The new Head of Safer Custody, appointed in April, had not been made aware of the issues highlighted by the area team.

97. It is disappointing that the learning identified by the ELR was not properly captured and handed over to the new Head of Safer Custody. We make the following recommendation to promote learning and support the new initiatives at Durham:

The Governor of HMP Durham should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines. In particular, staff should:

- **complete the immediate action plan within the set time-frame;**
- **make a considered, objective evaluation of all risk factors when assessing the risk of suicide and self-harm;**
- **set effective caremap objectives which are specific, time-bound and meaningful, aimed at reducing risk and updated at each case review;**
- **vary times of ACCT checks, while remaining within set observation periods, to avoid prisoners being able to predict when they will be checked;**
- **hold a post-closure review as soon as possible after the seven day post-closure monitoring period.**

Identification of risk at Holme House

Risk of suicide

98. We have not seen any evidence that Mr Hill was at increased or imminent risk of suicide and self-harm while he was at Holme House before the telephone calls with his girlfriend at 3.59pm and 4.09pm on the day he died when the pressure he was under from other prisoners came to a head. We do not therefore consider that staff could reasonably have predicted his actions or prevented his death.

Risk from others

99. It is evident from Mr Hill's telephone calls between 26 January and 3 February, that he was increasingly anxious about his drug debt and that two prisoners had threatened him with violence if he did not pay it. There is no evidence that Mr Hill shared his anxieties with staff until the day before he died. Mr Hill told staff that he was at most risk from his cellmate and refused to give any other names. An officer moved the cellmate to another cell immediately and the wing manager agreed Mr Hill would stay in his cell until he could be moved to a different houseblock. We consider that staff responded quickly and appropriately to manage the threat to Mr Hill based on the information available to them at the time.

100. Intelligence information that Mr Hill's girlfriend had attempted to pay money to other prisoners was linked to his security record on 1 February. All intelligence is triaged as presenting low, medium or high risk to the security of the prison. Low risk information must be processed in 72 hours, medium risk in 48 hours and high risk in 24 hours. The information relating to Mr Hill's girlfriend was correctly triaged as presenting low risk and had not been processed by the time he died.

101. Neither Mr Hill's threat to take his cellmate hostage nor the information that he was under threat from his cellmate and unnamed prisoners, resulted in information reports (IRs) being submitted. Although these would not have been actioned before Mr Hill died, it is important that such information is captured in order to build an accurate picture of violence and bullying across the prison. We make the following recommendation:

The Governor of Holme House should remind all staff of the importance of completing information reports (IRs) when they receive information about threats of violence and bullying.

102. Mr Hill's telephone conversations with his girlfriend contained the clearest evidence that he was being threatened by other prisoners and this was causing him anxiety. All telephone calls made by a prisoner to their personal contacts on the PIN phone system are recorded. Prisons are permitted to monitor telephone calls in certain circumstances, for example in response to intelligence about criminal activity and threats to the security of the prison and to ensure compliance with public protection arrangements. They are also permitted to randomly monitor no more than five percent of all mail and telephone calls each day. Random monitoring is afforded the lowest priority of all types of monitoring and prisons can choose to opt out of it entirely. There was no intelligence-led or public protection related reason to monitor Mr Hill's calls and Holme House had opted out of random monitoring when he died.

103. We consider that, had random monitoring been in operation, it is extremely unlikely the threats to Mr Hill would have been discovered and, even if they had, the discovery would not have changed the outcome for him. We make no recommendation.

Clinical care/good practice

104. The clinical reviewer concluded that Mr Hill's mental and physical healthcare at Holme House was equivalent to that which he could have expected in the community. There was a good handover between the Durham and Holme House Rethink teams, and this resulted in a swift assessment at Holme House. Since Mr Hill's death the Rethink team and Safer Custody team have established a new system to inform Rethink when prisoners' applications for HDC are refused. Although we do not think that Mr Hill's unsuccessful application for HDC is directly relevant to his death, this is an example of good practice.

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