Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Richard While, a prisoner at HMP Durham, on 4 July 2024

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.

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 Richard While died on 4 July 2024, after he was found hanging in his cell at HMP Durham. Staff and paramedics tried to resuscitate him but were unsuccessful. He was 48 years old. I offer my condolences to Mr While's family and friends.

Mr While had a long history of mental health problems and self-harm. He was monitored using suicide and self-harm prevention procedures (known as ACCT) throughout his six months at Durham. My investigation found that staff managed the ACCT procedures well and Mr While received good support from prison and mental health staff.

I make no recommendations.

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 **May 2025**

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Summary

Events

1. On 4 January 2024, Mr Richard While was remanded to HMP Durham charged with attempted wounding with intent.

2. Mr While had a long history of mental health issues and self-harm. He had paranoid schizophrenia, PTSD and emotionally unstable personality disorder with alcohol dependence. Mr While arrived at Durham with a suicide and self-harm warning form and had made cuts to his face during the journey from court. The reception officer started suicide and self-harm monitoring (known as ACCT).

3. Mr While remained on the ACCT throughout his time at Durham, which included a two-month period under constant supervision that ended in March. He spent nearly all his time in the Integrated Support Unit (ISU), a small unit for prisoners with significant mental health problems. Staff held frequent multidisciplinary ACCT reviews and Mr While had daily contact with mental health staff plus frequent psychiatry reviews.

4. Mr While continued to self-harm throughout his time in the ISU. These incidents tended to be triggered by anxiety about his ongoing court case. However, by the end of June, he seemed more settled and positive, though due to his risk of self-harm, he remained under ACCT monitoring.

5. On 3 July, Mr While's partner contacted the prison as he was concerned about a deterioration in Mr While's mental health. A mental health nurse tried to complete a care pathway with Mr While later that day, but he refused to engage. A psychiatrist also reviewed Mr While that day. He noted that Mr While was hearing voices and was anxious about his court case. They discussed changes to his medication to which Mr While agreed.

6. The same day, a supervising officer (SO) saw Mr While to check on his welfare after the death of a prisoner. The SO noted that Mr While said he felt fine and had no thoughts of suicide or self-harm.

7. On 4 July, at around 12.10pm, an officer locked Mr While back in his cell after lunch. Around 2.30pm, the same officer returned to unlock Mr While's cell. When he looked through the observation panel, he saw Mr While hanging from the ceiling light. He shouted to a colleague and they both entered the cell. His colleague radioed the emergency code blue. They cut the ligature and began chest compressions. Healthcare staff then joined them and continued with resuscitation attempts. Staff and paramedics continued with the resuscitation attempts but were unsuccessful. At 2.58pm, paramedics pronounced Mr While's death.

Findings

8. We found that the ACCT procedures were, overall, well managed. Staff held frequent multidisciplinary case reviews with good input from mental health staff. Mr While was on the ISU for almost all his time at Durham and he received a good level of support from both prison and healthcare staff.

9. The clinical reviewer considered Mr While's clinical care for his mental health and substance misuse was of a reasonable standard and was equivalent to that which he could have expected to receive in the community.

10. We make no recommendations.

The Investigation Process

11. HMPPS notified us of Mr While's death on 4 July 2024.

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

13. The investigator visited Durham on 17 July. She obtained copies of relevant extracts from Mr While's prison and medical records.

14. The investigator interviewed five members of staff at Durham on 11 September.

15. NHS England commissioned an independent clinical reviewer to review Mr While's clinical care at the prison. The clinical reviewer and investigator conducted joint interviews at the prison.

16. We informed HM Coroner for County Durham and Darlington of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

17. The Ombudsman's office contacted Mr While's daughter to explain the investigation and to ask if she had any matters she wanted us to consider. She asked if Mr While's partner could provide information. Mr While's partner and a friend then contacted us and told us about the times when they had contacted the prison with concerns about Mr While's deteriorating mental health. We have addressed this in the report.

18. We shared our initial report with HMPPS and the prison's healthcare provider, Spectrum CIC. They found no factual inaccuracies.

19. We sent copies of our initial report to Mr While's daughter and to Mr While's partner via his solicitor. Mr While's daughter raised some further queries which we have addressed in separate correspondence. Mr While's partner and his solicitor also raised further queries. We have added two paragraphs to this report in response and addressed other queries in separate correspondence.

Background Information

HMP Durham

20. HMP Durham is a local prison, serving the courts of Tyneside, Durham and Cumbria. Spectrum Community Health CIC provides primary healthcare services. Tees, Esk and Wear Valleys Foundation NHS Trust provides mental health services.

21. Within the prison is the Integrated Support Unit (ISU) run by Tees, Esk and Wear Valleys NHS Foundation Trust, a dedicated mental health unit for 13 prisoners. It provides intensive assessment and treatment for prisoners with acute and complex mental health needs. The unit is staffed with prison officers, support workers and mental health nurses each day.

HM Inspectorate of Prisons

22. The most recent inspection of Durham was in April and May 2024. Inspectors found that while the rate of self-harm incidents was increasing it was lower than in many similar prisons. Leaders worked proactively, including with prisoners, to understand the reasons, but they had yet to take sufficient action to address some of the common frustrations that led to men hurting themselves. These included staff not responding to basic requests, isolation and boredom caused by insufficient time unlocked, lack of meaningful activity and poor mental health.

23. In HMIP's survey, only half of those who had been supported through the suicide and self-harm prevention procedures (ACCT) felt cared for by staff, but many were more positive when spoken to directly. ACCT case management had become more consistent, but weaknesses persisted, particularly in care planning which was poor. Despite the wide range of support available it was rarely reflected in care plans. Inspectors were concerned that of the 31 ACCTs opened at the time of the inspection, only three prisoners were engaging in any purposeful activity.

24. The ISU provided intensive assessments and treatment for patients with acute and complex mental health needs. The physical environment had been enhanced with patient artwork and information displays. Patients were involved in planning activities and inspectors observed caring and compassionate interactions between the team of mental health professionals and officers who worked on the unit.

Independent Monitoring Board

25. 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, for the year to 31 October 2023, the IMB reported that the prison generally felt a safe environment.

26. The Investigator spoke to a member of the IMB who said that overall the ISU was well run. She said the IMB had seen staff interacting well with prisoners.

Previous deaths at HMP Durham

27. Mr While was the 14th prisoner to die at Durham since July 2021. Of the previous deaths, six were self-inflicted and seven were from natural causes. There was a self-inflicted death the day before Mr While's, though there were no similarities. There was also a self-inflicted death in March 2024. As a result of having three self-inflicted deaths within four months, Durham was identified as requiring additional support and monitoring from regional and national safety teams.

Assessment, Care in Custody and Teamwork (ACCT)

28. 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.

29. 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 multidisciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.

30. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

31. On 4 January 2024, Mr Richard While was remanded in custody, charged with attempted wounding with intent (of his partner). He was sent to HMP Durham. He had been in prison before but not for almost 30 years. He arrived with a suicide and self-harm warning (SASH) form completed by court staff as he had said he would self-harm and had been on six observations an hour, later increased to constant observations. Mr While had a long history of mental health issues, including paranoid schizophrenia, PTSD and emotionally unstable personality disorder with alcohol dependence, and had spent time in mental health hospitals. He also had a long history of self-harm, including by overdose, cutting and headbanging.

32. When Mr While arrived at Durham, staff noted he had cuts to his face. He told reception staff that he had made the cuts with a pen while in the prison van and had been headbutting the wall as he did not want to live. He told staff he had mental health issues and a long history of alcohol and drug misuse and wanted help. The reception officer started suicide and self-harm prevention procedures (known as ACCT) and set observations at one an hour.

33. The reception nurse booked Mr While for a Drug and Alcohol Recovery Team (DART) GP appointment and completed a referral to the mental health team. Mr While was prescribed antipsychotic medication.

34. On 5 January, Mr While inserted a plastic fork under his eyelid. A nurse cleaned the injury, referred Mr While to the GP and made another mental health referral. She arranged for all sharp objects to be removed from the cell.

35. The same day, a GP completed a review in the DART clinic. Mr While tested positive for cocaine and benzodiazepine. Mr While told the GP about his alcohol consumption and the GP prescribed medication to minimise the risk of alcohol withdrawal. Later that day, a mental health nurse completed a mental health assessment and created a mental health care plan.

36. At the first ACCT review that day, Mr While said he had been headbutting the cell wall as he felt stressed. He said he had self-harmed for a long time and at times did not want to be alive. He also had a long history of drug and alcohol misuse. He said he would try not to self-harm in prison but was very nervous. He spoke about his offence and said he had threatened to kill his partner after an argument but was very remorseful and wanted to make amends but did not know when his hearing was going to be. He agreed to accept help with his mental health issues. Staff set observations at two an hour with three quality conversations a day. (Mr While was not allowed contact with his partner until early March.)

37. On 7 January, Mr While told prison staff that he was an armed forces veteran and a local veterans group had supported him. Prison staff arranged for Mr While to continue to engage with the veteran support group.

38. On 8 January, an officer found Mr While sitting on his bed with a ligature around his neck attached to the top bunk. He was conscious. Staff placed him under constant supervision. A prison manager was appointed as his ACCT case manager.

39. On 9 January, Mr While was allocated a single cell in the Integrated Support Unit (ISU), a small unit for prisoners with significant mental health problems. On this unit he had daily contact with mental health specialists. He remained under constant supervision for the next two months. Apart from a period of four days from 18 to 22 January, when he was moved to E Wing because his ISU cell was needed, Mr While remained in the ISU. He had frequent ACCT reviews and psychiatry reviews. Psychiatrists assessed he was psychotic and that his engagement was poor but should improve as he responded to his antipsychotic medication. He had several self-harm incidents during his constant supervision including headbutting the wall, cutting himself with a plastic fork and trying to stick a heated vape in his eye. He was also found with a noose and a piece of razorblade. On 26 February, a prison manager discussed Mr While with a psychiatrist expressing concerns that Mr While's risk did not seem manageable in the prison setting. The manager had noted he had completed 24 ACCT reviews and there had been no significant change. The psychiatrist completed a referral for Mr While to be assessed for admission and treatment in a medium secure hospital and prescribed diazepam. However, Mr While was not accepted for a place because the assessing psychiatrist considered he could be managed in prison.

40. On 8 March, staff ended the constant supervision, and a custodial manager (CM) was appointed as Mr While's ACCT case manager. By this time, Mr While's mood had improved and he was engaging with staff and others on the unit. He had received a letter from his partner and had also asked for help in contacting other family members, including his daughter. Staff reduced observations to three an hour.

41. On 10 March, Mr While made scratches to his face using a drinks can he had found in a bin. A safer custody officer carried out a welfare check. When he asked Mr While why he had self-harmed, he said he was fed up. The officer decided to keep observations at three an hour pending the next ACCT review.

42. The next day, Mr While cut his eyelid open with a plastic fork. Nursing staff treated him. At his ACCT review later that day, Mr While said he had cut himself because he was anxious about his forthcoming video link court appearance. Staff discussed his use of plastic cutlery to self-harm and said he would need to hand his cutlery in once he had eaten, to which he agreed. Staff increased observations to four an hour.

43. On 12 March, staff spoke to Mr While's daughter by telephone. She said she would be happy to have contact from her father by phone, letter or video call. Mr While was very pleased about this. He subsequently exchanged letters with his daughter and spoke to her and his grandchildren on the telephone.

44. On 20 March, Mr While's partner contacted the prison and said he was concerned about Mr While following his video link appearance the previous day. A member of the safer custody team spoke to an ISU officer who said Mr While seemed okay as he had been socialising on the unit and had had an ACCT review. At the review, staff recorded that Mr While seemed in much better spirits and they reduced observations to three an hour.

45. A week later, staff reduced observations to two an hour after noting that Mr While had had another good week and had not self-harmed for over two weeks. The next

week, on 3 April, staff reduced observations to one an hour as Mr While had continued not to self-harm.

46. On 14 April, staff reported that during a phone call, they had heard Mr While saying he was going to kill himself. Mr While denied saying this. Staff were aware that there were ongoing issues with Mr While's bail application (which was unlikely to be granted) and increased observations to two an hour to provide more support.

47. On 20 April, Mr While's partner contacted the prison and said he was concerned about Mr While's mental health due to his impending court case (scheduled for 22 April). A member of the safer custody team spoke to ISU staff who said that Mr While was okay and was out on the exercise yard. They fed this back to Mr While's partner.

48. At his ACCT review on 23 April, Mr While said he thought he had been due in court the previous day and thought he might be getting out of prison. Staff told him that he had not been due to appear at the hearing the previous day and was not required to attend until 6 June. Staff noted that Mr While did not talk much about how he was feeling.

49. The next day, Mr While self-harmed by headbanging and said he had done this because he did not know what was happening with his bail application. He continued to bang his head over the next few days. He said he was frustrated about not getting bail as his partner (the alleged victim) had said he did not want to pursue the charges.

50. On 5 and 13 May, Mr While's partner contacted the prison with concerns about Mr While's mental state. Staff from the safer custody team conducted welfare checks on both occasions and Mr While said he was okay. Staff reduced observations to one an hour on 14 May.

51. On 17 May, Mr While made cuts to his wrists with a drinks can. A nurse dressed his wounds and staff removed the drinks can from his cell. At his ACCT review on 21 May, Mr While said it had had just been 'one of those things' and how he had felt at the time.

52. A member of the IMB told the investigator that she had spoken to Mr While on two occasions. The first was on 28 May, when Mr While had said he felt settled and outlined his plans for his life after prison. The second occasion was on 14 June, when Mr While had praised the unit and had told her that he liked the nursing staff and officers in the ISU.

53. At the ACCT review on 30 May, a CM, the interim case coordinator, recorded that Mr While had not self-harmed in over a month. (This was not the case as Mr While had self-harmed less than two weeks before.) He recorded that Mr While was future focused, had no thoughts of suicide and was grateful for the support he had received. The case review team reduced observations to three conversations a day and three observations at night.

54. Mr While attended court by video link on 7 June (it was moved back a day). He was told his hearing had been adjourned to 18 July. Staff recorded that they had no

concerns. At his ACCT review on 10 June, he said that he was a bit downhearted about the adjournment as he hated being in prison (he had also been refused bail).

55. Staff held ACCT reviews on 17 and 21 June in response to Mr While headbanging again. He said he was frustrated about his court case.

56. Mr While's last ACCT review was on 25 June. A CM chaired the review. An ISU nurse and a wing officer attended. The CM noted that Mr While had had a visit from the veteran's charity that morning and was in really good spirits. He talked positively about being sentenced and being transferred to the veterans' unit at HMP Holme House. The ISU nurse and wing officer said that Mr While had been more positive for a few weeks but as he was still prone to self-harm by headbanging, the case review team decided to keep the ACCT open. They maintained observations at three conversations a day and three observations at night.

57. On 28 June, during a mental health review, staff noticed superficial cuts to Mr While's neck. He said he had made the cuts with a razor taken from a communal bin. He handed over the razor and said he had no current thoughts of suicide or self-harm.

58. On 30 June, staff noted that Mr While had engaged in the regime and had showered, eaten and taken his medication. The next day, staff noted that Mr While had been out on the wing and had had a coffee, though he also said his head was "all over the place" and asked to see a doctor.

59. On 2 July, Mr While had a mental health review. Staff noted that he appeared to be displaying aggressive behaviour towards staff and he declined the offer to attend the gym.

60. The next morning, Mr While's partner contacted the prison with concerns about Mr While's deteriorating mental health. (During a phone call with his partner the previous day, Mr While was frustrated about not getting bail and about having to stay in prison even longer. He said that he did not like being in his cell all day and was going to either "kick off" or kill himself. He said before he would have had a drink but now he wanted to go for a walk and listen to music.) A safer custody officer told Mr While's partner that they were aware of Mr While's fluctuating mental health. It is not clear whether staff took any further action in response to Mr While's partner's concerns.

61. At approximately 11.00am, a nurse tried to complete a care pathway with Mr While to note his physical observations, and a log of his food and fluid intake as staff noted that when Mr While was struggling with his mental health his intake of food and fluid would significantly decrease. However, he refused to engage with her.

62. The same day, a DART practitioner conducted a review with Mr While. Later that evening, a nurse completed an overview of Mr While's day. She noted that Mr While had been out on the unit. He had accepted all his meals and medication without any issues. He had also had a review with a psychiatrist. The psychiatrist recorded that Mr While had scratched his neck with a plastic fork. He was anxious about his court case and was hearing voices. He told the psychiatrist that he had never been in the army and had lied about it. The psychiatrist could not tell whether this was true or

delusional thinking. He proposed changes to Mr While's medication, to which Mr While agreed.

63. Later that afternoon, a Supervising Officer (SO) spoke to Mr While about the death of another prisoner at Durham to check that the news had not affected him. He recorded that Mr While said he was fine and had no thoughts of suicide or self-harm.

Events of 4 July 2024

64. The investigator watched CCTV footage, body worn video camera (BWVC) footage and listened to staff radio communications from 4 July. She also obtained information from the North East Ambulance Service. The following account has been taken from all sources.

65. On the morning of 4 July, Mr While collected his medication between 8.45am and 9.00am, and then Officer A locked him back in his cell. A short time later, the officer returned to Mr While's cell and asked him if he wanted a shower. Mr While declined.

66. At approximately 10.30am, Officer A returned to Mr While's cell and unlocked the door for him to go for exercise. The mental health clinical lead briefly spoke to Mr While as he was required to complete homework for the dialectic behavioural therapy (DBT) course he was on. He told her he had not completed any homework.

67. Mr While went to the exercise yard and mixed with other prisoners from his unit. He then collected his lunch at approximately 11.10am and returned to his cell. He told Officer A that he would go the gym later that afternoon with the other prisoners from his unit. The officer locked Mr While into his cell at approximately 12.10pm.

68. Officer B carried out a routine roll check just after 12.10pm. In his statement, he said he saw Mr While sitting on his bed watching the television and Mr While waved at him. A short time later he heard shouting from Mr While's cell. When he went to the cell and asked him what was wrong, Mr While said everyone was torturing him. The officer said he offered reassurance and Mr While calmed down and went back to watching the television. Officer B told Officer A what had happened.

69. At approximately 2.29pm, Officer A went to unlock Mr While's cell door and through the observation panel he saw Mr While hanging from the ceiling light. In his written statement he said that he entered the cell and shouted to Officer B. They both entered the cell and Officer B radioed a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties that alerts healthcare staff and tells the control room to call an ambulance immediately). Officer A held Mr While as Officer B cut the ligature and put Mr While on the bed and began chest compressions. He said someone shouted to move Mr While on the floor and they continued chest compressions. Healthcare staff then joined them and continued with resuscitation attempts. Staff moved Mr While to the landing outside the cell for more room as they continued with the resuscitation attempts. Officers A and B were led away from the area.

70. The prison communication log notes that when the radio emergency code was called staff immediately rang for an ambulance. The ambulance log noted the ambulance arrived at 2.35pm and from 2.37pm the ambulance paramedics and

prison staff continued with the resuscitation attempts. However, at 2.55pm the paramedics pronounced that Mr While had died.

Contact with Mr While's family

71. The prison appointed two officers as the family liaison officers. They visited Mr While's daughter at her home at approximately 4.55pm on 4 July and broke the news that her father had died. Later that day she broke the news to Mr While's partner.

72. The next day Mr While's daughter asked one of the family liaison officers to provide further information to Mr While's partner. She rang him and offered her condolences and support.

73. The prison contributed to the cost of Mr While's funeral, in line with national guidelines.

Support for prisoners and staff

74. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoners support following all deaths in custody. Postvention procedures should be initiated immediately after every self-inflicted death and on a case by case basis after all other types of death. Key elements of postvention care include a hot debrief for staff involved in the emergency response and engaging Listeners (prisoners trained by the Samaritans to provide confidential peer-support) to identify prisoners most affected by the death.

75. After Mr While's death, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support. Listeners visited the wing to offer support and inform prisoners of the support available.

76. The prison posted notices informing other prisoners of Mr While'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 While's death.

Post-mortem report

77. The provisional cause of death was pressure on the neck due to hanging.

78. The toxicology report noted that Mr While had taken sertraline (an antidepressant that had been prescribed to him), lamotrigine (used to treat epilepsy and bipolar disorder which had been prescribed to him) and quetiapine (an antipsychotic medication prescribed to him) prior to his death. His blood sample showed he had a higher level of sertraline than expected for typical therapeutic use which could have caused some intoxication and presentation in the form of dizziness, nausea, agitation and drowsiness. However, any effects could not be determined. It was possible that there was an accumulation of sertraline in his blood following chronic use and post-mortem change.

Findings

Assessment and management of risk

79. Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody), which was in place at the time of Mr While's death, sets out the processes (known as ACCT) that staff should follow when they identify that a prisoner is at risk of suicide and self-harm. The PSI provides a list of risk factors and triggers that may increase the risk of suicide and self-harm. Mr While had several risk factors including a history of deliberate self-harm, mental illness diagnosis, personality disorder diagnosis and recent contact with psychiatric services. In addition, he had been charged with a violent offence against his partner.

80. Staff correctly started ACCT procedures for Mr While when he arrived at Durham and he remained under ACCT monitoring up to his death. Mr While had significant mental health issues and frequently self-harmed so was a complex prisoner to manage. We found that overall, the ACCT procedures were managed well. Staff held frequent multidisciplinary ACCT reviews and interim reviews in response to self-harm incidents. One exception to this was on 28 June, when staff noticed superficial cuts on Mr While's neck but no ACCT review was held.

81. There was mostly a consistent case coordinator and good input from mental health staff. For the most part, observations were set in line with Mr While's risk, which included two months under constant supervision. (We do not understand why observations were initially set at one an hour when Mr While arrived with a suicide and self-harm warning form that said he had been under constant observation, but accept that this had no impact on his death.)

82. We note that the review on 30 May, chaired by an interim case coordinator, recorded that Mr While had not self-harmed for over a month and the case review team reduced observations. In fact, Mr While had made cuts to his wrists on 17 May. This suggests that the interim case coordinator was unfamiliar with Mr While's recent behaviour and had not read recent entries in his prison record. This highlights the importance of having a consistent ACCT coordinator. If interim coordinators are used (and we accept that this sometimes has to happen to cover periods of leave), it is very important that they familiarise themselves with the case before holding a case review. We bring this to the Governor's attention.

83. Staff maintained ACCT observations at the same level throughout June and up to Mr While's death in July. We have considered if there was any evidence that Mr While's risk had substantially risen in the days before his death and whether observations should have been increased. Despite staff monitoring his risks and triggers, there is no evidence that at that time anything significant had changed for Mr While. He was frustrated about being in prison but expressed that he was willing to accept help to manage the complex nature of his mental health issues. As a resident in the ISU, he had frequent and easy access to mental health specialists and had seen a psychiatrist the day before he died. We are satisfied that there was no indication that Mr While's risk of suicide had increased and that the ACCT observation level was reasonable at that time.

Clinical care

84. Mr While had complex mental health issues and a long history of self-harm and alcohol dependence. He continued to self-harm throughout his time at Durham. The clinical reviewer considered that the clinical care for his mental health and substance misuse was of a reasonable standard and was equivalent to that which he could have expected to receive in the community.

85. The clinical reviewer noted that Mr While had frequent contact with a named nurse and a visiting consultant forensic psychiatrist. Healthcare staff also ensured he had treatment and medication for his psychosis and personality disorder as well as clinical monitoring and therapy. He was referred for assessment for a secure mental health unit but was not accepted. For his substance misuse issues, the clinical reviewer noted that DART staff provided responsive, consistent and proactive contact.

86. The clinical reviewer found that there were some shortcomings in Mr While's physical healthcare and she concluded that this aspect of his care was only partially equivalent to that which he could have expected to receive in the community. She made recommendations not related to his death which the Head of Healthcare will wish to address.

Governor to note

Support to staff

87. Some of the managerial staff told us that while they gave their own staff a lot of support following Mr While's death, there was little support provided to them. We bring this to the Governor's attention.

Good practice

88. There was evidence of good support provided to Mr While by prison staff. This included liaison with a local veterans' charity who continued to provide support to Mr While when he was in prison, and staff facilitating contact between Mr While and his daughter. Mr While was clearly appreciative of the support he was given by staff.

89. The clinical reviewer found that the care provided to Mr While by ISU staff was proactive, considered and person-centred, highlighting very clear plans of care with discharge planning.

Inquest

90. At the inquest, held from 5 to 14 May 2026, the jury reached a narrative conclusion:

"Died as a result of a self-suspension by the neck using a ligature but his probable intent cannot be ascertained."

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