Investigation into the circumstances surrounding the death of a man at HMP Holme House in April 2006

Report by the Prisons and Probation Ombudsman for England and Wales

September 2007

This is the report of an investigation into the death of a man who was found hanging in his cell at HMP Holme House in April 2006. The man was a remand prisoner, awaiting trial at Newcastle Crown Court charged with the murder of his former partner. This was the first time he had been in prison.

I would like to extend my condolences to the man's family for their loss.

Two of my investigators, conducted this investigation. The North Tees Primary Care Trust also conducted a clinical review into the man's care and treatment whilst at Holme House. I would like to thank the Governor of HMP Holme House, and his staff for their help and co-operation during this investigation. I am also grateful to the Cleveland Police for their ready assistance.

The man's family have been in contact with both Holme House prison and my investigation team from an early stage. A key part of the investigation was to ensure the family had the opportunity to raise any concerns. My investigator and one of my family liaison officers met the man's brother. In this report we have done all we can to answer the questions raised by the family.

The man had initially been identified as someone who might have been at risk of self harm, and was placed on an Assessment, Care in Custody and Teamwork (ACCT) plan. However, he appeared to have settled into the prison routine and, six days prior to his death, he attended a review of his ACCT plan at which it was decided that he no longer presented a risk to himself. The inquest concluded at Middlesbrough Coroners Court on 5 September and jury returned a verdict of suicide.

Stephen Shaw CBE
Prisons and Probation Ombudsman **September 2007**

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SUMMARY

The man was 47 years old when he was received into HMP Holme House as a remand prisoner charged with murder in January 2006. It was his first time in prison. He was correctly identified as a person who could be at risk of self harm and was therefore placed on ACCT, a system for managing prisoners in distress who might pose a danger to themselves.

Prisoners are fully involved in the ACCT process. They first have an interview with a trained assessor, from which an individual care plan is drawn up. They then attend regular case reviews, where a case manager reviews the care and support they receive.

The man was initially located in the prison's healthcare centre. He was kept under observation by staff and subsequently shared a cell with another remand prisoner. The man was described as quiet, preferring to read in his cell rather than associate with other prisoners.

The man and his cell mate got on well and were relocated together. The cellmate described the man as being like a fish out of water in relation to prison life. They were eventually located together on houseblock 4. The cellmate recalls that on one occasion the man returned to their cell after a legal visit and told him that he could be facing a sentence of 15 years.

The man was present at a review of his ACCT on 31 March. He told those present that he had come to terms with his situation, and felt a lot happier now that he had found his feet with the routines in the prison. After consideration he was removed from ACCT.

On 5 April, the cell mate appeared at Newcastle Crown Court, and afterwards was taken to HMP Durham. The man was therefore alone in his cell during the night of 5 April. He wrote several letters that night. The man was last seen alive at 5:22am on 6 April, by the night duty officer, who was carrying out the roll check. He was sitting on his bed and gave a thumbs up sign, indicating to the officer that he was alright.

At 6:15am, the man was discovered hanging in his cell from the toilet door. He had used a ligature made from a bed sheet. Despite attempts to save his life, the man was formally pronounced dead at 7:14am. Those searching his cell after his death found a number of letters written to his family and associates, indicating his state of mind.

A post mortem examination took place on 6 April. It found that he had died as a result of hanging. There was no evidence to suggest third party involvement.

This report makes six recommendations and identifies two areas of good practice.

THE INVESTIGATION PROCESS

1. The investigation was formally opened at HMP Holme House on 10 April 2006 by one my investigators. The Governor and his staff produced the man's core record and a number of other documents for examination. Notices were issued to staff and prisoners telling them of the investigation and inviting anyone with relevant information to make themself known to the investigation team. My investigators were given unrestricted access to the prison, staff and documentation relating to the man. My investigators were also able to speak with Cleveland Police in relation to issues of common interest.

2. The North Tees Primary Care Trust conducted a clinical review of the man 's care and treatment. A representative from the Trust also took the opportunity of visiting Holme House.

3. A Family Liaison Officer from my office contacted the man's brother and met with him, accompanied by my investigator. My investigation has attempted to answer the questions posed by the man's family.

4. The man's brother had the following concerns:

    - His brother had told his sister that the prosecution psychiatrist had asked him directly "if you had the opportunity to take your life would you?" and he had answered "yes". The man's brother wanted to know what was done with this information, and whether it was passed on appropriately so that his brother would receive the care he needed

    - The man was on an ACCT form and this was closed a short time before his death. His brother was concerned that the man was taken off the monitoring procedure, and wondered why his family were not informed or involved at any stage as they knew their brother best

    - The night that the man died was the first night he had spent alone in a cell. His brother had concerns that this did not trigger staff to watch him more closely or to re-open the ACCT.

5. My investigators wrote to HM Coroner, to inform him of the nature and scope of my investigation and to request a copy of the post mortem report. Upon completion, this report will be sent to the Coroner to assist him in his enquiries into the man's death.

BACKGROUND

HMP Holme House

6. Holme House is a category B prison for adult males, opened in May 1992. The prison primarily serves the communities of the Tees Valley, South West Durham, East Durham and North Yorkshire.

7. The prison was inspected in April 2005 by HM Chief Inspector of Prisons. Holme House was deemed to be a largely safe and well-ordered establishment, and suicide and self-harm prevention was found to be well managed. Many of the prisoners most likely to be at risk of self-harm were diverted to beds in the healthcare centre upon reception.

8. The report comments positively on detoxification services available to prisoners with substance misuse problems.

9. As at many prisons, ACCT has been introduced at HMP Holme House to monitor and support prisoners assessed as at risk of suicide or self harm. (The previous system was known as the F2052SH procedure.) Once placed on ACCT, the prisoner is observed at pre-determined intervals, according to the perceived level of risk.

10. Each prisoner is assessed within 24 hours and then reviewed at intervals decided on an individual basis. The ACCT guidance says that, to be effective, the review should involve the key people who know the person at risk or are involved in their care. The key questions for each review are listed as:

    - have the problems that caused the ACCT plan to be opened now been resolved?
    - if not, what needs to be done to resolve them?
    - have any further problems arisen that are now causing distress and more risk?
    - if so, what action can be taken to address these?
    - is the person at risk now in contact with friends, family or other support?
    - does the person at risk now have something in their lives that they feel good about?
    - if not, how can this be improved?

11. Over time, the reviews should also consider other factors such as:

    - distress – has anything changed to make the person at risk more or less desperate?
    - resources – has anything changed that makes the person at risk now feel more or less alone?
    - previous suicidal behaviour – has anything changed that makes suicide more familiar or more acceptable to the person at risk?
    - suicide intention or plan – has anything changed to show that the person at risk is more or less prepared to kill themselves?
    - pattern of self harm – is self harm becoming more or less frequent?

12. Amongst other things, the ACCT guidance states that prisoners should be cared for in a safe environment and it is for the Case Review team to decide the most appropriate place to locate an individual prisoner.

13. In relation to ACCT, HM Chief Inspector of Prisons noted that staff at Holme House had high levels of awareness and training. However, night duty staff had still not been provided with individual anti-ligature knives, despite the recommendations from previous investigations into deaths in custody. Overall, the inspectors found that the "ACCT approach to managing prisoners at risk of self-harm had been successfully introduced."

14. In addition, the Chief Inspector said ACCT documents were "well maintained, care plans were clear and meaningful, and there was evidence of high levels of engagement with the prisoners concerned."

15. The death of the man was the fourth apparently self inflicted death to have occurred at Holme House since April 2004 when I became responsible for all investigations into deaths in prison custody.

EVENTS PRIOR TO 6 APRIL 2006

16. In January 2006, the man was arrested by the police after allegedly fatally stabbing his former partner. He was taken to Durham Police Station. He was interviewed and charged with murder and subsequently appeared at Durham Magistrates' Court at the end of January. He was then taken by prison escort contractors to HMP Holme House. He was located in the healthcare centre. The cell had CCTV coverage to enable staff to monitor him closely.

17. The following day, the man was interviewed as part of the medical reception process. He was identified as having had depression. He also disclosed he had previously attempted to self harm, having made two suicide attempts in the previous three years. The man was prescribed chlordiazepoxide, a medication used to treat people detoxifying from alcohol.

18. Two days later, the Head of Residence, spoke with the man in the healthcare centre. The Governor was concerned for the man's welfare and instructed the clinical manager, to open an ACCT form. The Immediate Action Plan devised by the clinical manager and two nurses stated that the man's risk of self harm was to be managed by locating him in the healthcare centre in a cell with CCTV, and for staff to observe him on a 'frequent and irregular' basis.

19. During the morning of the next day, the man was assessed by a nurse. The guidance states that all prisoners who have an ACCT form opened must be formally interviewed by an ACCT assessor. The nurse noted that the man was 'not suicidal' and that he entertained 'no thoughts of self harm'. At 10.20am, again in accordance with the requirements of ACCT, a formal review of the man's ACCT took place. The clinical manager and three nurses were present, as was the man. The outcome of this review was that it was decided to keep him on his detoxification medication under observation in the healthcare centre. It was agreed that 'frequent and irregular' observations would be replaced by 'general observations', which essentially reduced the rate at which he was observed by staff. He was removed from the camera cell and located in another cell.

20. On 1 February, the man's ACCT plan was reviewed by the clinical manager, three nurses and the medical officer. During this review, the man disclosed that he was not sleeping and said that he felt suicidal at times. It was agreed that general observations and alcohol detoxification should continue as before. A review date was set for early February.

21. In February, the man appeared at Durham Magistrates' Court via a video link from Holme House. He was further remanded in custody. The next day, the man's ACCT form was reviewed by clinical manager and two nurses with the man again in attendance. It was noted that he

was ‘fed up of the system but has a good padmate who he gets on with well.’ The next review date was set for the next week.

22. On two days later, the man was relocated to houseblock 3 following an ACCT review involving the clinical manager, the Safer Custody Officer and the Medical Officer. The rationale behind the move was to reduce the amount of time the man had to dwell on his situation, as location on houseblock 3 provides more opportunities for education and work.

23. A week after his last review, the man’s ACCT was further reviewed by two officers alongside the safer custody officer. It was noted that the man ‘remains quite ambivalent regarding suicide’ and it was universally agreed that the ACCT document should remain open. The date of the next review was planned for 15 February. The man had by this time completed his detoxification programme.

24. Two days later, the man was relocated to houseblock 4. No ACCT review appears to have taken place on this occasion. In mid February, the man’s ACCT was reviewed again, this time by a Senior Officer (SO) and an officer. The man said that he felt he still needed the support offered by being subject to ACCT, and this was agreed by the senior officer and the officer. A review date of early March was set.

25. In early March, the ACCT review panel of a senior officer, an officer and the safer custody officer who agreed with the man that the ACCT needed to remain open as his situation was unchanged from mid February. It was noted that the man was still entertaining thoughts of self harm.

26. A week later, a further ACCT review took place. One of the two safer custody co-ordinators, an Officer and the man took part and agreed that the ACCT still needed to remain open. It was noted that the man ‘remains ambivalent re. self harm’ and that he is ‘quite emotional at times.’

27. A Consultant Psychiatrist, assessed the man at Holme House at the request of the Crown Prosecution Service (CPS) in March. Such psychiatric assessments are requested by the CPS in serious cases to assess the prisoner’s fitness to plead to the offences with which he or she has been charged. The report would normally only be available to the CPS and the trial judge.

28. In the psychiatrist’ s report dated 30 March, he said that on both occasions he saw the man he was cooperative and fully orientated, and presented as an intelligent man. There was no evidence of any cognitive difficulties. He followed the conversations on both occasions throughout and understood all the questioning. However, he was tearful and distressed at times, and noted he had a poor appetite but was sleeping well. He told the psychiatrist that he was on a continuous suicide watch in prison, would probably kill himself if the opportunity

arose, and said he was overwhelmed to be in prison and 'having nothing to live for.'

29. A copy of the psychiatrist's report was received at Holme House after the man died. My investigators have been unable to discover when it was received into the prison and by whom. The psychiatrist did not share the information with the prison at the time as he believed the man to be on a 'suicide watch'.

30. The man was interviewed for education classes on 14 March and also had a visit from his sister that day. On 15 March, he attended the outpatients department. Later that day, he attended his ACCT review where it was noted by a senior officer that he 'is still self isolating', meaning he was not mixing with other prisoners. The man enjoyed reading and would rather do this than go on association. It was agreed that the ACCT should stay open and a date of 1 April was set for the next review. On 17 March, the man was seen by a triage nurse who referred him to a chiropodist.

31. At 10:55am on 31 March 2006, a day earlier than originally planned, the man's ACCT plan was again reviewed. The man, a senior officer, and a trainee psychologist who had not met him previously but who is an ACCT assessor, were present. The man told the senior officer and the trainee psychologist that he had come to terms with his situation and felt a lot happier now that he had found his feet with the routines in the prison. He was receiving visits and maintaining outside links by telephone and letters. After consideration, all present agreed to remove the man from his ACCT plan. The post closure review, which is held to find out how the prisoner is doing without the consistent support of ACCT, was scheduled for 6 April 2006.

32. On Wednesday 5 April 2006, the man's cellmate attended a court hearing. At the conclusion of that hearing, he was relocated to HMP Durham. As a consequence, the man became the sole occupant of his shared cell.

33. Two other prisoners at Holme House, shared the cell next to the man. One of these prisoners recalled being in his cell during the evening of 5 April 2006 when he asked the man through their dividing wall if he had any stamps. The man told him he only had two and needed them as he was going to write letters. That was the last time the prisoner spoke to the man. The second prisoner, who was the wing barber, describes the man as a person who did not associate with other prisoners. He spoke to him whilst cutting his hair and described him as 'down', although they did discuss prisons to which the man might be sent in due course.

34. At 7:30pm on 5 April, an officer started night duty at Holme House. His first task was to account for all the prisoners in their cells in houseblock

4. At 7:45pm, he visited the man’s cell and saw that he was there alone.

EVENTS OF 6 APRIL 2006

35. One of the prisoners in the cell adjoining the mans', awoke in the early hours of Thursday 6 April and switched on Sky News. He noticed that it was 5:22am. He recalls that, within minutes, the night duty officer switched on his cell night light to check on him and his cell mate. The prisoner says the night duty officer would then have gone to the man's cell to check on him.

36. At 5:35am, the officer opened the flap on the man's cell door to carry out the morning roll check. He saw that the cell lights were on and that the man was sat up in bed, smoking a cigarette. The man indicated that he was alright, giving the officer the thumbs up sign. They did not speak. The officer was not expected to check on the man again and did not do so before his night shift ended.

37. An officer arrived at Holme House at 5:10am. He commenced his early morning roll check of the prisoners alone at 6:15am. He commenced his roll check on houseblock 4 on the third landing (the top floor) and worked his way down to the first landing (the ground floor) of each wing. He arrived at the man's cell, opened the cell door flap and looked into the cell. He could clearly see the man, hanging from the toilet door from a ligature made of a bed sheet. The man was wearing his prison clothes, blue jeans, and a maroon/blue jumper.

38. The officer immediately ran to the first floor office to summon assistance and collect ligature scissors and a ligature knife. (This took him a matter of seconds.) He notified the orderly officer (the senior officer in charge of operational matters in the prison). The orderly officer then raised the alarm using the prison radio system. He radioed 'code blue' which is the call sign when a prisoner's breathing may be compromised and gave the location as houseblock 4, cell A6. The call was logged at 6:36am in the Holme House control room log. An ambulance was called at 6:37am and arrived at the prison at 6:50am.

39. The officer ran back to the man's cell and was the first to enter. He noticed the ligature around the man's neck was placed over the toilet door and was secured through a hole in the door. The officer formed the opinion that the man was not breathing. The officer lifted the man's body to release his weight from the ligature and tried to cut the bed sheet with the ligature scissors. Despite several attempts, he could not cut through it.

40. As a result of the code blue call over the radio, a nurse attended the man's cell, accompanied by the night orderly officer and two officers. On arrival the nurse saw an officer holding the man with one arm whilst trying to cut the ligature with his free arm.

41. The officer was joined by another officer who managed to cut the ligature. Together they placed the man on the floor on his back.

42. The nurse examined the man and established that he did not have a pulse and was not breathing. The nurse and an officer commenced Cardio-Pulmonary Resuscitation (CPR). The nurse carried out chest compressions whilst the officer carried out artificial ventilation using an ambu bag.

43. The nurse and the officer continued with CPR until the ambulance crew arrived and took over at 6:54am. They established that there was no heartbeat or rhythm and CPR was stopped. The prison's doctor, pronounced the man dead at 7:14am.

44. The cell was then sealed and treated as a potential crime scene by Cleveland Police. At 9:49am, a governor and a senior officer, the prison's family liaison officer, left the prison to inform the man's family personally of his death.

POST MORTEM

45. The post mortem on the man was carried out by a pathologist at University Hospital North Tees on 6 April 2006. The pathologist gave the cause of death as hanging. There was no evidence to suggest third party involvement.

46. Two small incised wounds on the man's left ear were consistent with being caused when an attempt was made to cut the ligature around his neck with a knife.

47. I understand the toxicology results have given the coroner no cause for concern.

CONTACT WITH THE MAN'S FAMILY

48. A senior officer acted as the prison's family liaison officer, keeping a log of her contact with the man's relatives. As noted, a governor and the senior officer personally broke the sad news to the man's sister, on the morning of his death.

49. The senior officer remained in contact with the man's family and arranged for the prison to pay for his funeral costs. The man's brother has visited the prison and seen the cell where his brother died and spoken to the Governor.

50. I am pleased to record that the man's brother has been satisfied with the cooperation he has received from Holme House.

ISSUES CONSIDERED IN THE INVESTIGATION

Clinical care

51. North Tees Primary Care Trust undertook a clinical review of the man's care and treatment whilst he was at Holme House. The review confirms that he had ready access to nursing and medical care as appropriate to his needs.

52. However, the report does express concerns about the fact that the man disclosed to medical staff upon his reception at the prison that he had made two suicide attempts in the previous three years, but apparently no efforts were made to obtain his medical records. It is also noted that an entry in the prison clinical records dated 30 January mentions the man being referred for a mental health assessment. There is no evidence in the records to show that this assessment ever took place. Finally, the clinical reviewer has rightly pointed out that some entries in the clinical notes are not signed, dated or timed, a basic record-keeping requirement.

53. The clinical review consequently makes three recommendations, which I fully endorse:

- all entries in the records should be named, dated, timed and signed.
- all referrals to outside agencies e.g. Mental Health Team (MHT) should be documented and followed up.
- previous medical records should be routinely requested when a new prisoner is received at an establishment.

Concerns expressed by the family

54. The man had told his sister that the prosecution psychiatrist had asked him directly, "if you had the opportunity to take your life would you?" and that he had answered "yes". The family wanted to know what was done with this information and whether it was passed on appropriately.

55. A copy of a confidential Psychiatric Assessment on the man dated 30 March by the psychiatrist was found in the correspondence handed to my investigator. On the two occasions that the psychiatrist saw the man on 8 and 28 March, he was the subject of an ACCT plan. The man told the psychiatrist that he would kill himself if the opportunity arose. He was overwhelmed at being in prison and had nothing to live for.

56. My investigator wrote to the psychiatrist to ask if he shared any information with the Prison Service and, if so, with whom, when, and where. The psychiatrist told my investigator in a written response that he did not share any information with the Prison Service. He went on to say that, whilst the man was tearful, at no time did he show any

significant evidence of depression or anxiety. The man's tearfulness was more related to his concerns regarding his current situation and his uncertainty of how he would plead at the impending court hearing. The psychiatrist did not fully assess the man's mental state as he was not instructed to do so. The psychiatrist had no heightened concerns regarding the man's mental state. He noted that he was quite relaxed throughout the two interviews he conducted.

57. The man was on an ACCT plan that was closed six days before his death. The family was also concerned that he was taken off the monitoring procedure and wondered why they were not informed or involved at any stage, as they knew him best.

58. As I have shown, the man was taken off the ACCT plan because he, together with a prison officer and a trainee psychologist, decided after consultation that the man no longer presented a risk of self harm. The trainee psychologist had not met the man previously and had no prior knowledge of his history and presenting issues.

59. It is the view of the Prison Service Safer Custody Group, which devised and implemented ACCT and oversees its use in the Prison Service, that the staff present at each case review should know the prisoner and be directly involved in their care. Given that the trainee psychologist had not met the man before 31 March, and had not otherwise been involved in managing his care, I question whether it was appropriate for her to have been on the case review panel. I certainly have reservations about whether she was in a position to make an informed decision about the risk the man posed to himself, based on one meeting and a review of the available documentation.

    The Governor should consider whether, when deciding to close an ACCT plan, those making the decision should have been present at previous ACCT reviews.

60. At no point during the man's time in prison was consideration given to consulting with his family about the risk he might pose to himself. However, this now forms one of my recommendations.

    The Governor should also consider how to involve a prisoner's family in the ACCT process in accordance with ACCT guidance.

61. The man's family was further concerned that their brother died on the first night he had spent alone. They asked why this did not trigger staff to watch him more closely or to reopen the ACCT plan. However, because the man had been removed from the ACCT plan, he was no longer considered by staff to be at risk of self harm. Therefore, the fact that he was on his own in a cell for the first time would not have brought any greater attention to him.

Other concerns

62. I note that the officer found it difficult to cut the ligature with the ligature scissors. I am not sure why this was the case, but it would be prudent for the Governor to inquire further.

    The Governor should ensure that suitable anti ligature equipment and training in its use is provided.

63. A member of Holme House Independent Monitoring Board (IMB) had concerns that the first officer to arrive, was caused undue stress by being interviewed by the police for approximately one and half hours without any support from prison staff.

64. The officer has confirmed that he found being questioned by the police particularly difficult. He was ushered into a room shortly after discovering the man hanging in the cell and was not asked if he would like to be joined by a colleague or Trade Union representative. The police officer who interviewed him had not visited the man's cell, meaning that the officer had to repeat himself and go into unnecessary detail. His interview was also interrupted on more than one occasion; as a consequence, he was questioned for longer than might otherwise have been the case. I make no formal recommendation, but consideration should be given to ensuring prison staff are chaperoned and supported when giving evidence after a traumatic event.

CONCLUSIONS

65. When the man was in Holme House, he was correctly identified as someone at risk of self harm and placed on an ACCT plan. His ACCT plan had worked well for him between reception and when it was closed two months later.

66. Six days before his death, a prison officer who knew the man, and a trainee psychologist who did not, jointly reviewed the ACCT plan with him. The man presented well, and said he had come to terms with his situation and felt happier now he had found his feet with the routines of prison. They decided to remove the man from his ACCT plan.

67. On the day before his death, the man's cellmate went to court, and at the conclusion of his case was relocated to another prison. The man was therefore in his cell alone. He was no longer on an ACCT plan and therefore not subject to enhanced levels of observation.

68. The man was observed at 5:35am on 6 April, sitting on his cell bed smoking. He indicated to the officer carrying out his roll check that all was well by giving him thumbs up sign. When the 'early turn' officer carried out his roll check an hour later, the man was found hanging in his cell.

69. Given that the ACCT plan had been closed, I do not believe that Holme House could have done more to prevent the man's death. However, the investigation has raised questions about the make up of the ACCT panel, especially at a time when a decision was made to remove the man from monitoring and support.

70. The investigation has also highlighted again the need for staff to sign, date and time entries made in prisoners' records, a recurrent theme in many of my investigations and not as some may think a trivial and bureaucratic concern.

RECOMMENDATIONS

To the Governor

1. **The Governor should consider whether, when deciding to close an ACCT plan, those making the decision should have been present at previous ACCT reviews.**

2. **The Governor should also consider how to involve a prisoner's family in the ACCT process in accordance with ACCT guidance.**

3. **The Governor should ensure that suitable anti ligature equipment and training in its use is provided.**

To North Tees Primary Care Trust

4. **All entries in the records should be named, dated, timed and signed.**

5. **All referrals to outside agencies e.g. MHT should be documented.**

6. **Previous medical records should be routinely requested when a new prisoner is received at an establishment.**

Good Practice

1. The staff involved in administering CPR to the man should be commended for their attempts to save his life.

2. The prison's Family Liaison Officer should be commended for ensuring the man's family were kept fully informed of events after his death.