

**Investigation into the circumstances surrounding the
death of a man, a prisoner at HMP Durham,
in April 2009**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

June 2010

This is the report of the investigation into the death of a man. He was 39 years old when he took his own life in HMP Durham. I would like to extend my sympathy to his family.

One of our office's family liaison officers contacted the man's mother to explain our role and to offer the opportunity for the family to contribute to the investigation. I know that the death of a member of one's family is a difficult time, and this can be exacerbated when it happens in prison. I hope my report addresses the issues which the family may be concerned about. I am sorry for the delay issuing my report, and I hope this did not cause the family too much additional stress.

The investigation was undertaken by a senior investigator. Both he and I would like to thank the Governor of Durham and his staff for their participation, in particular the suicide prevention co-ordinator who acted as our liaison officer. A review of the man's clinical care whilst in custody was commissioned from the local Primary Care Trust (PCT), and this was carried out by a clinical reviewer. I am grateful to him for his review and input into this investigation.

The man had been in HMP Durham shortly before, and returned there on 3 April 2009. He was convicted and awaiting sentence when he was found hanging in his cell. No suicide note was found. Staff tried to resuscitate him, but he died on the way to hospital.

On an earlier occasion, the man was not put on the Prison Service's special support for those thought to be at risk of harming themselves when I believe it would have been appropriate. However, he was being monitored by these procedures when he did take his own life.

I make five recommendations concerning suicide and self harm monitoring and support for prisoners with mental health needs. I am pleased to see that the Prison Service has accepted my recommendations. The man's family had no comments to make on the draft report.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

Jane Webb
Acting Prisons and Probation Ombudsman

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SUMMARY

The man was a troubled young man with a history of mental health problems and drug misuse. He had spent time in HMP Durham previously, and returned there early in 2009.

When he arrived at Durham, escort staff noted that he had made a comment hinting that he wanted to take his own life. He told reception staff that he had been joking. He reported having no previous mental health problems, and his reception health screening did not raise any immediate concerns.

The day after he arrived at Durham, a member of the healthcare team conducted a standard check to see whether the man had any history of problems with his mental health. Some history was noted but, as there were no immediate concerns, he was given a routine referral for a psychiatric assessment. This would usually take some two to three weeks. The same day, his community mental health worker contacted the prison. His contact details were taken, but no details of his history were obtained.

On his birthday, the man sought medical assistance for three cuts to his leg, which he had apparently inflicted himself. A nurse treated his cuts, and advised that he should be placed on special measures for those prisoners thought to be at risk of harming themselves (known as Assessment, Care in Custody and Teamwork, or ACCT). However, poor communication amongst staff meant that this did not happen.

Over the following two weeks, the man's mental health seemed to deteriorate. Healthcare staff were called to see him on a number of occasions, but the emerging picture of his declining mental state was not recognised. On two occasions cellmates were removed from his cell because it was thought that he posed a danger to them.

On 21 April, a prison officer noted that the man appeared to be very depressed, and had not collected his evening meal. He went into his cell and spoke to him at some length. Concerned, he opened an ACCT document to ensure support and monitoring was provided for him. Sadly, despite this, the man took his own life in the early hours. Staff attempted to resuscitate him, and on their arrival paramedics detected a pulse and transferred him to hospital. Unfortunately, he died before the ambulance reached the hospital.

The Prison Service conducted an investigation into the events of 9 April. The report made a number of recommendations to prevent such an oversight from recurring. Furthermore, as the man's was one of three similar deaths at Durham in a short period of time, a thematic review was held into the circumstances of these three deaths. Again, this review made several recommendations to improve the management of prisoners at risk of self-harm.

I make five recommendations. They cover the holistic treatment of mental health issues, the procedures for reporting self-harm incidents and opening ACCT document, and the procedures for prisoners to see healthcare staff.

THE INVESTIGATION PROCESS

1. The investigation was formally opened at HMP Durham on 24 April 2009 by a senior investigator. He met the Acting Deputy Governor and was given copies of the man's core prison records, including his medical records. The investigator spoke to the suicide prevention co-ordinator, members of the chaplaincy, the prison's family link officers and one of the prison's police liaison officers. He was shown around the prison and saw the reception areas, the induction wing, the healthcare centre, and the wing where the man lived, including his cell. He spoke to a number of staff around the prison.
2. Notices were issued to staff and prisoners informing them of the investigation and inviting anyone with relevant information to contact the investigator. None was received. The investigator was given unrestricted access to the prison, staff, prisoners, and documentation relating to the man.
3. Prison officers and members of healthcare staff were formally interviewed, and those interviews were recorded. The interviews were transcribed and interviewees invited to sign and return copies, confirming their accuracy. All the transcripts were signed and returned, and are attached as annexes to this report.
4. The local Primary Care Trust (PCT) was asked to provide a clinical review of the man's care and treatment. It was conducted on behalf of the PCT by the clinical reviewer.
5. A Family Liaison Officer from the Ombudsman's office contacted the man's family to explain our investigation and offer the opportunity to participate. The family asked:
 - Given the prison's knowledge of his mental health problems and the fact that he was on an ACCT, why was he left alone in a cell?
 - Was he given proper observation through the night that he died?
6. The investigator 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, my report will be sent to the Coroner to assist his enquiries into the man's death.

HMP DURHAM

7. Durham prison opened in 1819 and was rebuilt in 1881. Since then it has maintained its primary role as a local prison serving courts in the north east. It is a category B prison housing adult male convicted and unconvicted prisoners. Durham operates a “non-collusive” regime whereby all prisoners, regardless of their offence, mix in all areas of the prison.

Mental health assessments

8. On reception into Durham, prisoners are asked whether they have any mental health difficulties. In addition, as part of their initial health screening, a nurse refers them to the mental health team if they assess that there are any issues which constitute an immediate danger. If so they are referred to the mental health team. If not, within one day of reception one of the prison’s mental health administrator checks to see if any new prisoners are known to outside mental health services. This is known as a Care Programme Approach (CPA) check and is made through contact with the relevant outside mental health team. If a prisoner has had contact with community mental health services, he will be booked to see a member of the prison’s mental health team. Depending on the mental health issue identified, they will be given a referral within 48 hours, within seven days, or a routine referral. Routine referrals may take two or three weeks.

Suicide and self harm monitoring

9. As at all prisons, Assessment, Care in Custody and Teamwork (ACCT) procedures have been introduced at Durham to monitor and support prisoners assessed as at risk of suicide or self-harm. Once placed on ACCT, the prisoner is observed at pre-determined intervals according to the perceived level of risk. Each prisoner is assessed within 24 hours of the ACCT being opened, and then reviewed at intervals decided on an individual basis.

Previous deaths at HMP Durham

10. Since the Ombudsman became responsible for investigating deaths in custody, in April 2004, there have been 15 deaths in Durham prior to the man’s, and four since. There have been deaths in similar circumstances. Following a number of similar deaths over a short period, the Prison Service conducted a review. I refer to this in my report.

Her Majesty’s Chief Inspectorate of Prisons

11. HM Chief Inspector of Prisons last conducted an announced inspection of Durham in September 2006. Following the inspection, she said that the prison had satisfactory arrangements for prisoners at risk of self-harm. The systems to identify and support prisoners at risk of self-harm were generally of a good standard, and most ACCT forms demonstrated a

thoughtful and caring approach. Reviews were held on time and were of a reasonable quality. There were, however, problems with implementing recommendations from previous inquiries into deaths in custody. She also reported that there was a considerable amount of undetected bullying in the prison.

Independent Monitoring Board (IMB)

12. Each prison in England and Wales has an Independent Monitoring Board responsible for monitoring day-to-day life in the prison and to ensure that proper standards of care and decency are maintained. The last report published by the IMB for Durham was the annual report for the period 1 November 2007 to 31 October 2008.
13. The report states that Durham is “grossly overcrowded” and that this can have an affect on the quality of life for prisoners as well as increasing the risk to safety and wellbeing of prisoners and staff. The Board are critical of the state of the healthcare centre, and say that it is not suitable to the provision of modern healthcare and needs to be replaced.
14. Board members check ACCTs on a weekly basis. The annual report comments on the variable quality of the ACCT documentation.

KEY FINDINGS

HMP Durham 26 March to 31 March

15. The man was convicted on 26 March 2009 of a number of offences. He was not sentenced at that stage, and was remanded to Durham. A printout in his file from the Police National Computer (PNC) contained warnings about self-harm, mental health, and hepatitis C.
16. As with all prisoners, the man was given a reception health screening when he arrived at Durham. Standard clinical observations including his blood pressure, height, weight and pulse, were taken. He told staff carrying out the screening that he had no mental health issues. He was referred to the substance misuse team because of his high level of alcohol use. He saw a prison doctor who noted that he appeared well and showed no signs of withdrawal. He was allocated to E wing, which is the induction wing.
17. The following day the man saw Nurse A on the substance abuse team as part of his detoxification programme. He reported very heavy alcohol use over the last six months.
18. On the same day, a Community Psychiatric Nurse (CPN) from the local hospital telephoned the prison. He spoke to one of the mental health administrators. The CPN said that the man was one of his clients and he had received information that he was in Durham. The administrator confirmed this, but, on checking the man's record, said that there was a mental health referral had not been made. The CPN commented that he would be surprised if the man had been willing to see the mental health team. He did not express any concerns about him, but left his contact details should the prison wish to speak to him. The administrator entered a note on the healthcare computer system (EMIS) detailing his conversation. As the man's CPA check (for previous mental health issues) was imminent and no concerns had been expressed, he did not speak to the mental health co-ordinator about the telephone call.
19. The CPA assessment was duly carried out the following day and the man's contact with the local hospital was noted. He was not thought to require immediate intervention from the mental health team, and was given a routine referral. (This was subsequently superseded when he saw a member of the mental health team on 20 April and was booked for mental health assessment on 23 April.)
20. The man was seen as a matter of routine by Nurse B in the blood-borne virus clinic on 30 March. He declined a blood screening, telling her that he had been tested in the local hospital two years previously.
21. Nurse A reviewed the man on 31 March to assess how he was coping with alcohol withdrawal. All his clinical observations were normal, and so he was discharged from clinical monitoring. The same day, he was bailed.

HMP Durham 3 April to date of death

22. The man returned to Durham on 3 April. The notes from his first night induction and initial assessment show that he had returned to prison with a suicide/self-harm warning from escort staff. He had apparently made a comment about wanting to shoot himself. The notes also indicate that he suffered from depression. He was seen by healthcare staff for health screening, and once again referred for alcohol detoxification. He saw the prison doctor and claimed that earlier reports that he wished to take his own life were untrue. He said he had no intention of harming himself, and was coping with withdrawing from substance use. He told the doctor that, in the short time he had been out of prison, he had been drinking alcohol as well as taking cannabis and amphetamines.
23. A cell sharing risk assessment was conducted, and concluded that the man presented a low risk of harm to others if sharing a cell. The assessment noted his comment about wanting to take his own life, but he said he had been joking. The assessment did not identify any concerns.
24. Because he had been out of prison for such a short period, the man spent less time under observation from the substance abuse team than would usually be the case. He saw Nurse A on 4 April, and told her that he had no mental health issues or any thought of suicide or self-harm. Nurse A said in interview that she would refer a prisoner to the mental health team if previous concerns were raised or if she detected any mental health issues herself. This was not the case for the man. She reviewed him again on 6 April. He had seen an Integrated Drug Treatment System (IDTS) worker but it had been explained to him that they worked with people withdrawing from drugs, not alcohol. Nurse A noted that he looked well, and did not display any withdrawal symptoms. He was therefore discharged from clinical monitoring.
25. The man's records contain an unidentified computer printout dated 6 April. This includes a reference to him having been admitted as a formal patient under the Mental Health Act in 2004.
26. It was the man's birthday in April. Still located on E wing, he was warned for using his cell call bell for non-emergencies. He was further warned for going to other prisoners' cell doors when asked not to. He refused to undergo a secondary health screening that morning.
27. At approximately 3.30pm that afternoon, prisoners on E wing were locked in their cells unless they were due to collect a prescription from the clinic. Nurse C was conducting the clinic, which was held on the ground floor of E wing. The man pressed his cell bell, which was answered by Officer A. He asked if he could be unlocked to go and see the nurse.
28. The usual procedure when a prisoner wants to see a member of the medical team would be for wing staff to put the request to healthcare, and

a nurse would be sent over to the wing to assess them. However, in practice, if a nurse was on the wing and a prisoner asked an officer if he could see a member of the medical team, the officer would usually ask the nurse if they would be willing to see the prisoner. In this case, Officer A agreed to let him speak to the nurse. In interview with the Prison Service investigator, Officer A said that he did not question him as to why he wanted to see the nurse. He unlocked him and let him make his own way down to the treatment hatch.

29. While Nurse C was conducting the clinic, Officer B was supervising prisoners queuing at the treatment hatch. She was approached by the man. He was not due to receive any medication, but told her that he had been sent to see the nurse to have some cuts to his leg treated. He lifted his trouser leg and showed her what she described in interview as three scratches. She therefore took him out of the queue and asked Nurse C to see him.
30. Nurse C saw the three cuts to the man's shin, which he cleaned and dressed them. He noted the history of self-harm and depression. The man told him that he had been feeling stressed, but by this time felt better. He then left the treatment room.
31. Officer B said in interview that she did not see the man after he saw Nurse C, and that he returned to his cell. But she did recall Nurse C telling her that wing staff would need to complete an F213SH form (a note of a self-inflicted injury). He advised that the ACCT procedures should be opened, and noted the man's medical record to that effect.
32. Each wing landing has a member of staff nominated on a daily basis as in charge (IC). Throughout the day the officer is responsible for unlocking prisoners for work, undertaking the roll count (confirming the number of prisoners on the wing), and dealing with any queries that arise. In interview, Officer B told the Ombudsman's investigator that she spoke to the IC to pass on Nurse C's message about completing an F213SH form and opening an ACCT. However, the IC told the investigator that she did not recall such a conversation. The incident is not recorded in the wing observation book or in the wing history file and an ACCT was not opened.
33. The man was moved from his cell on E wing to a cell on the ground floor in A wing on 17 April. A note was made in the wing observation book that he was due to see a mental health nurse the following morning because of some issues about his medication. He had told wing staff that he had paranoid thoughts, but there was no note of this in his wing file or in healthcare.
34. There is no note of the man seeing anyone the next day but, on 19 April, a note in the wing observation book reports that he was acting strangely and erratically. He said that he wanted to go to the segregation unit as his head was "in bits". He claimed to suffer from schizophrenia, and asked to be given diazepam (a sedative which relieves anxiety) as he felt stressed.

He said he was not receiving his medication (healthcare staff confirmed to wing staff that he was not due to receive any medication). He asked the staff to remove his television from his cell as it was “stressing him out”, but then changed his mind. Wing staff asked a member of healthcare staff to come and assess him.

35. Nurse D came to A wing and spoke to the man. She decided that there was no evidence of acute mental illness when she saw him, and he was not due any medication. He was aware of what was going on around him. She noted that he had a referral for a mental health assessment following his CPA check. Wing staff were asked to observe him and contact healthcare again if necessary. His cellmate was moved to another cell for his own safety.
36. The following day, on 20 April, wing staff were once again concerned that the man was behaving in a strange manner. Healthcare was contacted, and the mental health co-ordinator, asked a Community Psychiatric Nurse to go to him. She told the investigator in interview that she is given a daily list of prisoners to assess, and her day is scheduled around that. Any requests to see additional prisoners have to be fitted around her listed work.
37. The psychiatric nurse made her way to A wing and saw the man. She did not have the opportunity to look at his medical record before doing so. He provided her with some background, but it was rather disjointed. He told her that he had been seen at the local hospital, and had possibly been admitted a year previously. He had been prescribed medication in the past, although he did not recall what it was. He said that he had suffered poor sleep, paranoia, hearing voices, and fleeting thoughts of suicide. Although he had harmed himself three weeks ago, he told her that he did not have any current thoughts of doing so again.
38. In interview, the psychiatric nurse said that the man’s biggest concern seemed to be that he had no telephone credit. This upset him as he said that his mother was ill with cancer, and he was unable to speak to his two children, with whom he said he remained in contact. She did not have time to conduct a full mental health assessment, but did not have any immediate concerns about him. She said she was going to book a full assessment for 23 April, and would apply for his notes from the local hospital. He expressed that he was content with such an approach. In the meantime, she asked wing staff if he, despite having no telephone credit, could use the telephone to alleviate his foremost worries.
39. Another cellmate had been located with the man, but because of his erratic behaviour, this cellmate was also removed for his own safety. Because of this, a Senior Officer (SO) asked Officer C to complete a Security Intelligence Report (SIR). The SIR recommended that the Safer Custody team should be made aware that two cellmates had had to be removed from sharing with the man. This would in turn prompt a review of his cell sharing risk assessment.

40. During the early hours of 21 April, at approximately 1.30am, the man alerted staff that he was having trouble sleeping. Wing staff asked healthcare to come and see him, and Nurse E did so. He asked for some medication, but the nurse refused the request. She offered some advice on relaxation techniques, but he declined. She advised him to make an appointment to see the doctor later in the morning. She also asked wing staff to “keep an eye on him”.
41. The records do not indicate whether the man did see a doctor on 21 April. At 6.50am, Officer D unlocked him to allow him to attend court. He pointed out that he was not due to attend court that day. In interview, Officer D said that the man had not given him any cause for concern at this point, appearing to be neither depressed nor agitated but simply pointing out that he was not due in court.
42. At some point that day the man was reassessed for sharing a cell. Because of his paranoid behaviour, his Cell Sharing Risk Assessment was upgraded to “high”. The assessment mentioned aggressive behaviour towards cellmates, and noted the self-harm comment he had made whilst being escorted to prison. The assessment stated that he should be in a single cell due to his mental state.
43. Later that afternoon, when unlocking prisoners to collect their evening meals, Officer E noticed that the man seemed to be distressed. His head was bowed, and he appeared to have been crying. Officer E asked him if he was okay, and he replied that he was. He went to the serving hatch, but when he returned to his cell Officer E noticed that he had two flasks but had not collected any food.
44. Officer E once again asked the man if he was okay, and he repeated that he was. The officer was nevertheless concerned about him, and followed him into his cell. He pressed the man about his problem, and he said that he felt very depressed. He told Officer E that his mother was ill with cancer, and he was unable to contact her as he had no telephone credit. He did not have any tobacco as his canteen provisions had not yet arrived (they were due that evening) so Officer E gave him two cigarettes.
45. Officer E noticed that the man had no bedding, so arranged for some to be brought to the cell. He also had some food brought to the cell in case he changed his mind about eating. Officer E asked if he wanted to speak to a Listener (Listeners are prisoners trained by the Samaritans to provide support to other prisoners) but he declined. He also said that he did not want to use the confidential Samaritans’ telephone. He said that he wanted to be moved to the segregation unit, but Officer E suggested that healthcare might be a better option. He said he would ask healthcare staff to see him in the morning, which he seemed content with.
46. Returning to the wing office, Officer E opened an ACCT document for the man. The ACCT noted that he had not eaten for two days, though

whether this was known by staff or whether he reported this himself is not clear. Healthcare and the Safer Custody Team were informed that the ACCT had been opened. He said that he was not receiving his medication, although none was prescribed at the time. The document stipulated that he should be checked twice per day and twice at night. The ACCT would be reviewed the following morning. A note was put in the wing observation book to make all staff aware that he had been acting erratically and been placed on an ACCT.

47. Entries on the man's ACCT document show that he was checked at 7.00pm and at 8.30pm, when he told staff that he was okay. When the prison is in night state, the Night Orderly Officer (NOO) is in charge of the operation of the establishment. The NOO on 22 April was a Principal Officer (PO). He checked the man's ACCT document and noted these comments at 10.10pm.
48. An Operational Support Grade (OSG) was on duty on A wing that night. Amongst the other duties at night, staff complete a circuit of the wing every half hour. There is an electronic system, known as pegging, where staff have to register at various points around the wing. The OSG said in interview that he would conduct any ACCT observations in addition to and separately from his normal circuits of the wing. He saw the man at 11.40pm, noting that he remained in his clothes, and was talking to himself. The OSG was aware that the man had some problems with his mental health, and was not alarmed by his behaviour. He also checked him at 3.50am on 22 April, noting that he was lying on his bed. The OSG noted no concerns.
49. At approximately 5.30am the OSG began a roll check of the wing. He began on the fourth landing, and reached the ground floor landing some ten minutes later. When he opened the observation panel on the man's cell, he saw him suspended from the toilet door handle by a ligature, made from his bedclothes, around his neck.
50. During the night, once prisoners are locked in their cells, the doors and gates between wings are open, allowing staff within the secure perimeter free access around the prison. The radio network is open (so all staff with radios can hear all messages). Staff are therefore able to respond to emergencies speedily. On finding the man, the OSG immediately called an emergency across the radio network, making it clear that a ligature was involved. This call went across the radio network at 5.40am. He then banged on the cell door, trying to get a response from the man.
51. Staff around the prison heard the emergency call and began to respond. The first to arrive were the IC and Night Officer A, who were working on E wing and B wing respectively. They arrived at the man's cell at approximately 5.41am. At night the NOO is the only person in the prison with keys to access all areas which remain locked. Staff on the wings have access to cell keys which are held in sealed pouches. The seals are only to be broken and the keys used in an emergency. In interview, the

OSG said that, after he made the emergency call and tried to get a response from the man, other staff arrived before he had had the opportunity to consider whether he should open his emergency pouch. The IC broke the seal on her emergency key pouch, and the night officer opened his cell door. The night officer supported the man whilst the IC used her anti-ligature knife to cut him free.

52. When the NOO heard the OSG's emergency call over the radio, he was in the gate house with his deputies. The NOO immediately requested an emergency ambulance. It was called at 5.43am. All three members of staff then made their way to the man's cell.
53. The emergency response member of healthcare staff on duty that night was Nurse E. She was in the healthcare centre when she heard the emergency radio call, and immediately made her way to A wing. Another nurse was also on duty that night, Nurse F, and she also went to A wing. Nurse E arrived as the officers were cutting the ligature. Nurse F arrived closely behind.
54. Night Officer A and the IC laid the man on the cell floor, and the IC and Nurse E began to perform cardio pulmonary resuscitation (CPR). Nurse E managed the airway, whilst the IC performed chest compressions. They continued until the paramedics arrived at 5.50am and took over. At this point the NOO sent Night Officer B to the gate, and asked Night Officer C to get an escort bag (the equipment used when staff need to accompany a prisoner to hospital). He asked OSG B to begin a log of events.
55. The paramedics initially got no response from the man but, after some medical treatment, they found a pulse. At 6.24am they decided to transfer him to hospital. The ambulance left the prison at 6.30am, with an escort officer. The Acting Deputy Governor and a locum doctor had been contacted, and both arrived at the gate as the ambulance left. The Acting Deputy Governor entered the prison but the doctor, seeing the ambulance leave, did not. At 6.40am, the escort officer telephoned the prison and informed them that the man had died.
56. The Governor held a hot debrief at 7.30am. (Hot debriefs are held as soon as possible after a death in custody to allow staff to raise any issues, and provide support if necessary.) The staff care team attended and offered support to any staff who felt they needed it. All prisoners on ACCT documents were re-assessed within 24 hours.
57. Prison staff had considerable difficulty identifying and locating the man's next of kin. Eventually, the police managed to trace his mother. Police officers went to the man's mother's address and told the family of his death that evening. Subsequently, two of the prison's family link officers went to visit the family the following day.
58. The man's family told the Ombudsman's family liaison officer that they received a good level of support from the prison. The prison's family

liaison officer had been very sensitive and helpful. The family had accepted an invitation to visit the prison. The prison had also offered financial assistance with the funeral.

Post mortem

59. The post mortem was opened on the afternoon of 22 April. However, there was a query over the fact that the man seemed to have two separate ligature marks on his neck so it was suspended whilst police officers returned to his cell in Durham for further examination. The separate ligature marks seemed to have been made as his weight shifted from the step in his cell. The post mortem was thus concluded the following day, 23 April.

Internal investigation

60. The Prison Service conducted an internal investigation into the circumstances of the man's self harm harming himself on 9 April. The investigation was carried out by a pathologist of the North East Regional Office. The investigation concluded that the failure to open an ACCT after an apparent incident of self-harm was caused by bad communication between the staff involved, and a lack of understanding about where the responsibility lay. The report made a number of recommendations which the prison is taking forward.

Prison Service thematic review of three deaths in a short period

61. The man's death was one of three self-inflicted deaths in Durham within a period of a few weeks. All three prisoners had been supported by the ACCT process at or near the time of their deaths, so the North East Region Safer Custody Advisor carried out a review. His findings on reviewing the man's ACCT forms included:

- The frequency of observations did not support the establishing of any meaningful interaction with the man.
- It is not clear why the initial assessment did not take place on the evening of 21 April and was instead scheduled for the next day.
- The care provided did meet the time limits of the Prison Service Order (PSO) which provides guidance on procedures for suicide prevention and self-harm management but the quality of care was less than it could have been.
- The man's ongoing mental health problems meant that he would have benefited from a long-term care plan.

62. The Safer Custody Advisor was also critical of the level of management checks carried out on the ACCT forms for all three prisoners. However,

the review found that any procedural weaknesses did not contribute directly to their deaths.

63. The review concluded that the suicide and self-harm procedures at HMP Durham in relation to the three prisoners did not meet the necessary standards. The procedures were not applied with the required quality, detail and management overview.

ISSUES

Reception at Durham

64. On arrival at Durham, the induction procedures seem to be of a good standard. Even if no mental health problems are reported or are apparent, prisoners' details are checked for previous mental health issues (the CPA check), usually within 24 hours. The man was correctly identified as requiring assessment, as he had previously had some mental health problems. As there was no reason to regard this as urgent, he was listed for a routine assessment. The clinical reviewer agrees with me that this was reasonable.

Ongoing monitoring of the man's mental health

65. Although the initial evaluation was reasonable, I have found that there were a number of points at which the man's mental health assessment could have been brought forward.

66. Having heard that the man was in prison, his outside mental health worker telephoned Durham before the CPA check had taken place. The member of staff who took the call noted the call and the CPN's contact details. He subsequently checked the man's records, noted that he was due for a CPA check, and so took no further action at this time.

67. The clinical reviewer comments in his review that it would have been good practice to have obtained a summary of the man's mental health history from the CPN when he telephoned. I agree. Although there were no immediate concerns at that stage, the man was scheduled for a CPA check and the mental health administrator is not clinically trained. It was a missed opportunity to obtain background information on a prisoner who had already been noted to be at risk of harming himself.

68. I consider the circumstances of 9 April, when an ACCT was not opened, in more detail below. But an episode of self-harm by someone with known mental health issues is a point at which a mental health assessment should have been prioritised. This was not done.

69. Nurse C made an entry on the healthcare computer system that an ACCT should be opened. So, even though this did not happen at the time, Nurse C's recommendation was visible to staff looking at the man's medical record. Nurse D saw him on 19 April after wing staff reported erratic behaviour. He told her that he suffered from schizophrenia. Nurse D did not see any evidence of acute mental illness and, noting that he had a mental health review pending, asked staff to observe him.

70. It is the clinical reviewer's opinion that with the developing picture of the man's history, along with the missed recommendation, that he should have been put on an ACCT at this point. In addition, Nurse D should have discussed the case with the duty doctor or the mental health team. The

clinical reviewer further says that by this stage a fuller psychiatric history should have been sought and the timing of his mental health review reconsidered.

71. The following day, 20 April, the psychiatric nurse was asked to see the man because of his erratic behaviour. By this stage the picture of mental health issues was building considerably, but she went to see him without reading his medical history. The clinical reviewer says that by this point obtaining a full psychiatric assessment should have been a priority, possibly for the duty doctor. She said that she would obtain his notes from the hospital. The clinical reviewer points out that the man's medical record had been requested on 26 March and, with this in mind, she should have more actively sought the records, speaking to either the hospital or to his community doctor by telephone. The notes from the hospital were never obtained. The clinical reviewer once again says that, as one was not in place, an ACCT document should have been opened at this time.
72. The man again asked for medical staff to come to see him on the wing in the early hours of 21 April. Nurse E came to see him and he said that he was having trouble sleeping. The clinical reviewer writes that, in view of the man's history, a more thorough assessment was merited.
73. The assessments the man underwent on his arrival identified that he had a history of mental health problems. He was not considered to be in urgent need of assessment and so was scheduled for a routine appointment. However, as time went on, even though the need for a psychiatric assessment became more pressing, there does not appear to have been a holistic view taken of his care whilst it was pending. Each time he had contact with healthcare, the episode seems to have been dealt with in isolation. The clinical reviewer concludes that he received a standard of medical care below common and acceptable medical practice. He recommends that, when it becomes known that a prisoner has mental health issues, the prison should adopt a more proactive approach to obtain a history of their problems. I suggest that the Head of Healthcare looks at ways to ensure that, when prisoners require several interventions from healthcare, their overall care is considered in its entirety.

The Head of Healthcare should consider systems to ensure that prisoners requiring frequent contact for mental health issues are identified and assessed accordingly.

Why was an ACCT document not opened on 9 April?

74. Prison Service Order (PSO) 2700 sets out procedures for suicide prevention and self-harm management. The PSO says that "all incidents of self-harm must be reported on incident report forms and an F213SH self-harm form must be completed". When the man asked to see Nurse C on 9 April for the cuts he had apparently made to his own leg, the self-harm form was not completed.

75. PSO 2700 also says that “in the event of any incident of self-harm staff must (where there is not one open already) open an ACCT plan. This must be done no matter what the reason for the self-harm”. As with the self-harm form, an ACCT was not opened on 9 April, even though Nurse C noted that one should be.
76. In usual circumstances, if a prisoner asks to see a member of healthcare staff, a nurse will be called to come to the wing to see him. In practice, if a member of healthcare staff is on the wing at the time, discipline staff might ask them to see the prisoner. This is what happened on 9 April. The man asked Officer A if he could see a nurse without disclosing why. The officer therefore did not know that the man had harmed himself. When the man spoke to Officer B, he told her that he had cut himself, and she assumed that he had told whichever member of staff had unlocked him from his cell. To her mind, therefore, someone else had prior knowledge that he had cut himself and thus the responsibility to open an ACCT was not hers. Nurse C accepted that a self-harm form should be filled out and an ACCT opened. As he passed the man back into the care of Officer B, he asked her to ensure that an F213SH and an ACCT were opened. But he did not do so himself as he believed that the responsibility lay elsewhere.
77. In interviews, the assumption amongst staff was that the responsibility for opening an ACCT lay with the first person to identify any vulnerability in a prisoner. However, this is an unsafe assumption. An ACCT document can be opened by any member of staff who is concerned about a prisoner. As they are centrally logged, if someone tries to open an ACCT on a prisoner who, unbeknownst to them, is already on an ACCT, this will be identified. Staff must not assume that “someone else will do it”, or make assumptions about responsibility. If a prisoner’s wellbeing is thought to be at risk, then an ACCT must be opened.
78. Officer B sent the man back to his cell and, in interview with the investigator, said that she spoke to the IC to say that an F213SH and an ACCT were required. However, the IC told both the investigator and the clinical reviewer in interview that she had no recollection of Officer B speaking to her that day. Officer B also told the clinical reviewer that she spoke to Officer A about Nurse C’s instructions. Officer A told the clinical reviewer that he did not recall Officer B speaking to him that day.
79. It is clear that there was a breakdown in communication. The trail of information between staff was confusing which resulted in neither an F213SH nor an ACCT being opened.
80. The internal investigation identified this, and included recommendations to try and prevent such a scenario occurring again. The recommendations covered the documentation of medical treatment, including self-harm issues, the notifying of senior staff about any issues of self-harm, procedures for prisoners to seek medical assistance, and procedures around dealing with issues of self-harm.

81. The investigator spoke to the Deputy Governor and discussed how the recommendations from the internal review were being taken forward. The managers with responsibility for the recommendations had been tasked with ensuring that they had been acted upon. These were the Head of Healthcare and the Head of Residence. The Head of Residence had asked the residential governor with responsibility for safer custody to take responsibility. The investigator spoke with them. They were all in the process of ensuring that the recommendations were acted upon, although a planned, final co-ordinated response was not at that stage in place.
82. Although covering the same ground as some of the findings of the internal review, I strongly recommend that the Governor and Head of Healthcare clarify for staff about the completion of self-harm reporting forms and the opening of ACCTs. If an ACCT needs to be opened, it must be opened. The system should be regularly reviewed to ensure that it is working.

The Governor and the Head of Healthcare should ensure staff are fully aware of the procedures for completing self-harm reporting forms and for opening ACCT documents.

The Governor and the Head of Healthcare should remind staff that the appropriate wing manager should be informed of any incidents of self-harm.

83. A part of the breakdown in communication in this case stemmed from the man being unlocked from his cell because he asked to see a nurse. I do appreciate the busy environment of a wing, and that it may be convenient to ask a nurse who is on the wing to see a prisoner. However, if prisoners need to see a member of the medical team, then there must be proper co-ordination between staff. I recommend that the Governor and the Head of Healthcare remind staff that there must be full communication between staff when a prisoner requires medical treatment. Any necessary documentation must be discussed and completed.

The Governor and the Head of Healthcare should remind staff of the procedures for arranging for prisoners to see healthcare staff.

Telephone credit

84. The man told the psychiatric nurse on 20 April and Officer E on 21 April that one of his main sources of anxiety was that he did not have any credit to use the telephone. His telephone account was used three times on 20 April and twice on 21 April. When the investigator first visited the prison, he was told that there was a suggestion that someone else might have been using his phone credit. This may have been with his permission, as it was believed that the other prisoner might have been involved in a relationship with a relative of the man's. His records contain no reference to this, and none of the staff interviewed who dealt with him were aware of it.

85. The investigator subsequently received information that confirms that a former cellmate was using his telephone credit. He said that he did so with the man's permission as he was not in contact with any of his family. This was subsequently confirmed with the family themselves. The Safer Custody Manager confirmed to the investigator that there were no reports to suggest that the man was being bullied for his telephone credit.
86. It may be that the man was previously unconcerned about not having telephone credit but, in his anxious state, focussed on this. It may also be that he had inadvertently given away all his credit, without meaning to do so. I can do no more than speculate on this point. The man told the psychiatric nurse and Officer E that the lack of telephone credit was important because he was unable to contact his mother, who was seriously ill. The man's mother subsequently confirmed that she was not in contact with him.
87. However, if prisoners are using other prisoners' telephone credit, the prison should be aware. I do not make a recommendation, but would draw this to the Governor's attention so that a tighter rein may be kept on use of telephone credit.

Events leading up to and including the opening of an ACCT on 21 April

88. When Officer E was concerned about the man's wellbeing on 21 April, an ACCT was opened. I have found that Officer E displayed a good standard of care in spending time with the man and trying to ensure that he was being looked after.
89. However, in the period leading up to Officer E doing so, the man's care seems to have been less rigorous. It is noted on the ACCT form that the man was designated as needing to be in a single cell on 20 April. The staff observation book says that his cellmate was moved for his own safety on 19 April. A security report says that the man's cellmate was moved for his own safety on 19 April, but another prisoner was put in the cell with the man the very next day and subsequently removed for his own safety the same day. A cell sharing risk assessment noted that two cellmates had been moved, and the man was reclassified as a high risk of sharing due to his paranoid behaviour and danger to any cellmate. Moreover, the ACCT form stated that by the time it was opened, the man had not eaten for two days. This does not seem to have been recognised or at least was not acted upon until this point.
90. The Prison Service's thematic review of the three deaths said that the frequency of observations and conversations set in the man's ACCT was slightly confusing and did not encourage the establishment of meaningful contact with him. The review also said that it was unclear from the documents why the initial assessment did not take place on the evening of 21 April and was instead scheduled for the next day. This is within the time limits in the guidance, but the report noted that there was still a

significant amount of time before evening lock up and a duty assessor would have been available to conduct the assessment.

91. The clinical reviewer writes that, in view of what was known about the man by this point, the care plan was inadequate. He considers that a full psychiatric screening should have been undertaken immediately. He recommends that when an ACCT is opened on a prisoner with psychiatric concerns they should be assessed by an appropriately trained professional. This seems to me to make good sense, and I repeat the recommendation.

When a prisoner for whom there have been mental health concerns is placed on an ACCT, they should be assessed by a mental health professional.

Staff response

92. When the man was found in the early hours the staff response was swift and appropriate. All the prisoners who were on open ACCTs were reviewed within six hours of his death.

CONCLUSION

93. The man was a young man with a history of mental health problems. He arrived in Durham and, although his history was identified, he was considered as not requiring urgent intervention and given a routine referral for assessment. But over the following weeks, a number of incidents occurred which should have given rise to concern.
94. Following the man harming himself in early April, I judge that he should have been placed on ACCT monitoring for prisoners at risk of harming themselves. However, a problem with communication between staff meant that this did not happen. In the days before his death, his mental health appeared to be deteriorating. Two cellmates were moved for their own safety, and he needed to see healthcare staff on a number of occasions.
95. It appears that the man's mental health issues were never considered properly. Each time he saw a member of healthcare staff the matter in hand was largely viewed in isolation. He did not undergo a formal psychiatric assessment. His notes from the hospital were not obtained. The fact that he had a mental health assessment pending seems to have been seen as a safety net which would resolve all the strands of his problems. Sadly, he took his own life before the assessment took place.
96. Although he concludes that the man's medical treatment fell below acceptable standards, the clinical reviewer stresses in his review that, even had his recommendations been applied, it may not have prevented his death. I agree that it is unlikely that his death could have been prevented. However, I hope that the shortcomings identified are addressed and help to keep other prisoners safe.

RECOMMENDATIONS

The Head of Healthcare should consider systems to ensure that prisoners requiring frequent contact for mental health issues are identified and assessed accordingly.

The Prison Service accepted this recommendation. The Mental Health Co-ordinator is to review the present systems and amend and put into place improved/new systems as necessary. The target is that this should be achieved by September 2010.

The Governor and the Head of Healthcare should ensure staff are fully aware of the procedures for completing self-harm reporting forms and for opening ACCT documents.

The Prison Service accepted this recommendation. The prison training department is to conduct a rolling training programme for ACCT. In addition, healthcare staff are to be reminded of the principles of good record-keeping and standards in relation to the completion of self-harm reporting forms and ACCT documentation. The target is that this should be achieved by September 2010.

The Governor and the Head of Healthcare should remind staff that the appropriate wing manager should be informed of any incidents of self-harm.

The Prison Service accepted this recommendation. Advice will be cascaded to staff. The target for completion is June 2010.

The Governor and the Head of Healthcare should remind staff of the procedures for arranging for prisoners to see healthcare staff.

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When a prisoner for whom there have been mental health concerns is placed on an ACCT, they should be assessed by a mental health professional.

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