

**The death in custody of a male prisoner  
at HM Prison Durham in May 2004**

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

**June 2005**

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This is the report of an investigation into the circumstances surrounding the death of a male prisoner at HM Prison, Durham on 24 May 2004.

A post mortem examination carried out on 25 May 2004 concluded that the prisoner's death was caused by hanging.

The investigation was conducted under the terms of the transitional arrangements agreed between my office and the Prison Service that came into effect on 1 April 2004. In keeping with that agreement, a Senior Investigating Officer (SIO) carried out the bulk of the investigative work on my behalf under the guidance of my colleague. This report is based on the evidence provided by the SIO.

I commissioned an independent clinical review of the management of the prisoner's health needs during his time in custody at Durham. This was carried out by a representative of the Durham and Chester-le-Street Primary Care Trust (PCT), to whom I am most grateful.

My thanks go to the SIO and his assistant as well as to the Governor and staff at Durham for their co-operation during this investigation.

The prisoner was just 25 when he died. Like all too many of the prisoners whose deaths I investigate, his life had been wrecked by drugs. He also had mental health problems and had self-harmed in the past. A pre-sentence report prepared by the Probation Service had warned sentencers of the deceased's potential for self-harm should he be sent to prison.

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

**June 2005**

## 2. Summary

The prisoner was born in 1978. He came from a loving family. However, by the time he was 13 he had become a user of drugs such as cannabis, LSD, speed and ecstasy. Later he was to become addicted to heroin. He left school at 15 with no qualifications. For most of his adult life he was unemployed.

In October 2003, he was sent to prison for 30 months for a drug related offence. Concerns had been expressed in a pre-sentence report written by the Probation Service that, if he were to be sent to prison, he would be at risk of self harm. This information was not received at HMP Durham until a week after the prisoner had arrived there.

The day after his reception at Durham, the prisoner was made subject to self-harm monitoring procedures after his parents reported that he wanted to kill himself. A form F2052SH (a self-harm monitoring document) was opened. On 27 October, he was transferred to Acklington prison. On 29 October, the F2052SH was closed. At Acklington, the prisoner was twice involved in fights after which he claimed that he was under pressure from other prisoners. The Governor of Acklington commissioned an internal investigation to ascertain whether the prisoner was being bullied. The investigation found no evidence to suggest that any bullying had occurred.

On 18 February 2004, a further F2052SH was opened after the prisoner deliberately cut his own throat. He was returned to Durham the next day and was immediately admitted to the healthcare centre. The F2052SH that had been opened on 18 February at Acklington was closed at Durham on 18 April.

On 24 April, the prisoner threatened to hang himself. Once again a F2052SH was opened. At 3:00am the next day, he deliberately cut his throat again.

At about 8pm on 24 May, the prisoner was found hanging in his cell in the healthcare centre. All attempts to revive him failed. He was pronounced dead at the scene by the prison doctor at 8.53pm.

The investigation has found that the prisoner's mental health and risk of self harm were, in general terms, well managed. However I make observations about aspects of the use of the form F2052SH, the management of the incident in which the prisoner was discovered hanging, and the claims that he was being bullied at Acklington

I make four recommendations.

### **3. Investigation methodology**

The investigation began on 28 May 2004 when the Senior Investigating Officer and his assistant met with the Governor of Durham, and with representatives of the Independent Monitoring Board (IMB), and the local branch of the Prison Officers' Association (POA). The investigators familiarised themselves with the healthcare centre and the cell in which the prisoner died. Contact was made with the Coroner's Office and with the local police who were handling the enquiry.

The investigators examined the prisoner's files as well as policy documents relating to the general operation of Durham prison. Additional reports, including the most recent Independent Monitoring Board Annual Report, the relevant HM Chief Inspector of Prisons' reports, the most recent Standards Audit report, the Quality of Prison Life report, the Self Audit Report on self-harm and the reports of the investigations of two previous deaths in custody at Durham, were also examined. The investigators met the prisoner's father and spoke to him on the telephone at some length. The transcripts of the prisoner's last two telephone calls with his parents were also studied.

A number of staff and prisoners were interviewed.

#### **4. The deceased**

The prisoner was born in 1978. He enjoyed a positive and loving relationship with both his parents and with his two sisters. However, by the time he was 13 he had become a user of drugs such as cannabis, LSD, speed and ecstasy. He left school at the age of 15 with no formal qualifications. He later became addicted to heroin. For the most part, he lived with his parents on a farm which he helped to run.

The prisoner was arrested in April 2003 for a drug related offence and was bailed. In October 2003, he was sentenced to two and a half years imprisonment. He had not been in prison before.

In prison, he was described as a somewhat reserved man who responded positively to authority. He smoked heavily and suffered from depression.

The prisoner died in the healthcare centre at Durham on 24 May 2004, a month before his 26<sup>th</sup> birthday.

## **5. Durham and Acklington prisons**

- **Durham**

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 northeast. At the time of the investigation it held both male and female prisoners. Its certified normal accommodation was 636 but its operational capacity was 724. The accommodation for male prisoners comprises five wings. At the time of the investigation A, D and E Wings held convicted prisoners, C Wing was the first night centre and B Wing held remand prisoners.

The healthcare centre, where the prisoner died, is a two-storey building only a short distance from the main residential area of the prison. At the time of the investigation, it could hold up to 19 prisoners in a mixture of single and double cells.

The establishment was last visited by Her Majesty's Chief Inspector of Prisons in August 2003 when the male side was inspected, and again in January 2004, when the female unit was inspected.

The prisoner's death was the 12<sup>th</sup> death at Durham since August 2002.

- **Acklington**

Acklington is a category C prison near the small town of Amble in Northumberland. It can hold up to 882 male adult prisoners.

## **6. Events at Durham and Acklington prisons**

### **Pre-sentence**

On 12 September 2003, the prisoner appeared at Durham Crown Court where he was convicted of a drug related offence. He was to be sentenced at a later date. On 9 October, a pre-sentence report was completed by his Probation Officer. The report indicated that, although a custodial sentence would be justified for the offence he had committed, there were serious concerns about the possibility that he would self-harm if he was sent to prison. He had self-harmed in 2002 and was currently suffering from depression. The report recommended that the court should impose a Community Rehabilitation Order. An Offender Assessment form completed by the same Probation Officer on 6 October reaffirmed that the prisoner had cut his wrists in 2000 and had attempted suicide in 2002 because of his drug addiction and his subsequent depression. However, the Probation Officer also recorded that the prisoner had said he had since received help and that he currently did not have any suicidal thoughts. The Probation Officer nevertheless took the view that the imposition of a custodial sentence might increase the risk of self-harm. On 17 October, he was sentenced to 30 months imprisonment and was sent to Durham prison.

### **Durham Prison: 17- 28 October 2003**

Upon his arrival at the prison on 17 October, the prisoner underwent a first reception health screen. The Offender Assessment form was not received at the prison until 24 October. The Probation Service's concerns about his risk of self-harm were therefore not known to the staff who screened him. The prisoner said that, although he had seen a doctor in the preceding 12 months about his drug addiction, he had no current concerns about his health. He admitted that he had cut his wrists three years earlier but did not currently feel suicidal. He indicated that he would like to see a doctor. The reception health screen form does not clarify whether the prisoner was regarded as being fit for normal location, (i.e to be allocated to a wing rather than to the healthcare centre or to a specialist unit). On the same day, the prisoner was seen by a doctor who noted that there was no previous medical history and that he was in good health. Surprisingly, the doctor indicated in the record of his assessment of the prisoner that there was no evidence of self-injury. The doctor did, however, record that the prisoner was experiencing drug withdrawal symptoms. He was therefore placed on a 10-day detoxification programme, and was prescribed Lofexidine, a drug used to treat opioid withdrawal symptoms. A cell-sharing risk assessment completed that day concluded that the prisoner was not at risk of harming other prisoners. At section two of the risk assessment form, it was recorded that there was no evidence that the prisoner had ever been subject to F2052SH procedures. He was allocated to a shared cell in C Wing, the first night centre. No F2052SH was opened.

The Substance Misuse Team compiled a care plan for the prisoner, the aim of which was to assist him to remain free from drug misuse. The targets set out for him in the care plan included physical education, harm minimisation, relaxation, substance

misuse awareness, and healthy living skills, each of which was to be provided either by the PE department or by the Substance Misuse Team itself.

The next day, the prisoner's parents visited him. During the visit he told them that he wanted to hang himself. The prisoner's parents passed this information on to staff who decided to open a F2052SH straightaway. The wing manager considered that it was appropriate for the prisoner to be managed in the wing rather than in the healthcare centre. He recorded in the document that the prisoner said that he had tried to manipulate his parents in telling them that he wanted to hang himself. The manager noted that the prisoner was to receive support from staff, from the healthcare centre and from Listeners. Healthcare staff were consulted. They agreed with the wing manager's assessment that the prisoner did not need to be admitted to the healthcare centre, but they reaffirmed that he should continue to share a cell.

On 21 October, a F2052SH case review was held. This was attended by a multi-disciplinary team. The review summary recorded that the prisoner's lack of sleep was having an adverse effect on his state of mind. The prisoner nevertheless appeared to be positive during the review and looked forward to taking part in the full regime of the prison once his detoxification programme was completed. The F2052SH was to remain open for the following week.

On 23 October, an entry made in the prisoner's F2052SH suggested that he had started to think about what he had done to himself and his parents. He regretted telling his parents that he was going to kill himself, and had been in touch with them since saying that he no longer wanted to self-harm and never wanted to use drugs again. On 24 October, staff recorded in the F2052SH that the prisoner felt that he had no problems for which he needed any help. On 25 October, he told a member of staff that he had only threatened to hang himself because he was "rattling", an expression used by drug addicts to describe the effects of withdrawal, and because he could not cope with being in prison. The prisoner said that his "rattle" was now over, and that he no longer had any intention of harming himself.

On 26 October, the prisoner told staff that he had slept well. He was getting on well with his cellmate and wanted the F2052SH to be closed. However, the document remained open as the prisoner was to be transferred later that week.

#### **Acklington Prison: 28 October 2003 - 19 February 2004**

On 28 October, the prisoner was transferred to Acklington as a category C prisoner. The F2052SH was still open.

The next day, the prisoner attended a reception board at Acklington at which he told staff that his F2052SH was closed. It was pointed out to him that this was not the case and that a review was due to take place that afternoon. The case review was convened at 3:15pm and was attended by a multi-disciplinary team. The review summary describes the prisoner as having settled well at Acklington and preferring the establishment to Durham. He told the team that his withdrawal from "smack" had caused him to feel the way he had and that these feelings had now passed. The team decided that the F2052SH should be closed.

On 3 November, the prisoner's substance misuse care plan was evaluated. The evaluation sheet recorded that all the targets set out on the day of his reception had been met.

There were no further events of any significance until 26 December, when the prisoner was involved in a fight with another prisoner. At the ensuing adjudication (disciplinary hearing) held on 2 January 2004, he said that his jumper had gone missing and this was the reason for the fight. He was given seven days cellular confinement and stoppage of half his pay. On 17 January, the prisoner admitted to staff that he was under pressure from other prisoners. His prison file does not contain any details of what action was taken by staff. The prisoner's father later told the Senior Investigating Officer that his son had appeared very apprehensive during a visit at the prison in January. This was whenever any prisoner walked behind him, as if he was expecting to be attacked. The prisoner's father also said that, in February, his son had terminated a visit early so that he did not have to return to his wing in the company of the other prisoners in the visits rooms at the time.

On 10 February, the prisoner was seen by a Community Psychiatric Nurse (CPN) at his own request because he was hearing voices and was becoming increasingly paranoid. He told the nurse that he had been moved from one wing to another because prisoners were "winding him up". He thought that some prisoners were in possession of a camera and were watching him. He found it difficult to believe that he was having such thoughts. He reported that he kept hearing two male voices that gave a running commentary on his activities. He was aware that he would laugh at what the voices said. The prisoner also claimed that he had used cannabis and other drugs since he had been in prison, but that he had never experienced hearing voices before. He thought he was "cracking up" and needed help. He did not, however, want to be "sectioned off" (transferred under the Mental Health Act to a hospital for the mentally ill). The nurse told him that she would discuss his case with the mental health in-reach team the following week.

On 13 February, the prisoner was disciplined for possession of an illegal drug. The next day he was involved in a fight with another prisoner, during which he sustained a minor injury to his elbow. At the ensuing adjudication on 16 February, he gave as the reason for this fight that he and the other prisoner were "winding each other up". On this occasion he was given 14 days stoppage of half his pay, and seven days forfeiture of canteen, use of his private cash and association. Initially he was reluctant to return to his wing, but later changed his mind. The Governor carried out an investigation to ascertain whether the prisoner had been bullied. That investigation found no evidence that any bullying had occurred.

On 17 February, the prisoner was again visited by his parents. The next day he spoke to staff about an "evangelist" shouting at him. He appeared to staff to be depressed. On 18 February, he deliberately cut his throat with a razor blade while in his cell. Having done so, he panicked and pressed his cell bell to alert staff. He was taken to outside hospital where a number of stitches had to be inserted in his wound. The prisoner later claimed that he self-harmed because other prisoners thought he was a paedophile and because he could not cope with the voices he kept hearing. No completed F213SH (a form on which the details of any injury caused by an act of

self-harm are recorded) was included in the evidence presented to the investigators. However, a F2052SH was opened.

The next day, the prisoner was seen by a visiting psychiatrist. In a letter he then wrote to the prison doctor, the psychiatrist said that the prisoner admitted to him that he had contemplated suicide during the afternoon of 18 February, and had tied some sheets together. The prisoner said that he regretted what he had done and no longer felt suicidal. The psychiatrist wrote that the prisoner had accepted that he was suffering from some form of mental illness and had agreed to take a daily dose of five milligrams of Olanzapine. This is an antipsychotic drug prescribed for the treatment of schizophrenia. It can be used to treat symptoms such as hallucinations and thought disorders as well as emotional and social withdrawal. The psychiatrist suggested that the decision as to whether the prisoner could be safely contained at Acklington was a matter for the prison's managers. He recommended that, if there were further concerns, the prisoner should be transferred rapidly to a facility in which he could be adequately monitored, such as the healthcare centre at Durham. The prisoner was then interviewed by the D Wing management team. The prisoner told them that he thought people were reading his mind and that they were going to kill him. He initially indicated that he wanted to be treated as a vulnerable prisoner so that he could feel more secure. He also said that other prisoners were making threats against him. However, staff felt that there was no evidence to substantiate his claims. The team came to the conclusion that the prisoner's psychological problems could only be managed in a unit where full time medical care was available. It was therefore decided that the prisoner should be moved back to Durham that day.

#### **Durham prison: 19 February - 24 May 2004**

Upon his arrival at Durham, the prisoner told reception staff that he felt calmer now that he was back and that, although he was still hearing voices, he did not feel suicidal. He was nevertheless admitted to the healthcare centre. He was prescribed a course of Olanzapine, and a nursing care plan was compiled. Included in the nursing targets were daily one-to-one sessions with the on-duty nurse to allow the prisoner to express his thoughts and feelings, and regular feedback sessions with the nursing staff so that he was involved in the management of his own care.

On 21 February, a multi-disciplinary team convened a F2052SH case review. The prisoner told the team that he was confused about his mental health problems but he would not elaborate. He said that he no longer harboured thoughts of self-harm and felt comfortable in the healthcare centre. He was encouraged to take part in education classes and to associate with other prisoners. The support plan for him listed the following: "chapel, education/association, staff support, normal observations, probation". Apart from the reference to his participation in education classes and association, the plan did not set out any specific and measurable targets for him to achieve. Neither did it specify what measurable help he was to be given by staff. The F2052SH was to remain open.

On 22 February, a family member rang the prison to say that, during a phone call, the prisoner had threatened to harm himself. The next day he was offered a phone call to his mother, but he declined, saying that he believed that it was not necessary.

On 26 February, a psychiatric assessment was carried out. The doctor recorded on the Inmate Medical Record (IMR) that the prisoner was still hearing voices, and that his symptoms were still suggestive of drug related psychosis. The doctor also noted that schizophrenia and/or transient psychotic episodes could not be ruled out.

On 28 February, the prisoner was visited by his parents. Nothing of any significance occurred during this visit.

An entry made in the prisoner's F2052SH on 29 February indicated that he had no thoughts of self-harm or suicide at that point.

A further multi-disciplinary F2052SH case review took place on 5 March. On this occasion, the prisoner said that, although he was still suffering from occasional anxiety and paranoia, he had no thoughts of self-harm. However, the team noted that he looked tired and pale and that this was because he was not sleeping properly. The support plan required that the F2052SH should remain open, that the prisoner should be encouraged to interact with others in the healthcare centre, and that he was to remain subject to normal observation. No reference to the details of the telephone call to his family on 22 February was made in the record of the case review.

On 9 March, the prisoner refused to take any further doses of Olanzapine, claiming that the medication did not work. The next day, he changed his mind and asked to be allowed to take Olanzapine. An entry made in his IMR suggested that "no suicide or self-harm ideas had been offered".

On 11 March, a doctor carried out a further assessment of the prisoner. The doctor noted that the prisoner was now certain that "somebody was inside him and that this man was controlling his thoughts." He also recorded that the prisoner told him that he had thoughts of hanging himself during the previous week but had resisted doing so because he was worried about his parents who had separated. The doctor decided to increase the prescription of Olanzapine to 10mg by night and 7.5mg Zopiclone by night for the following week. Zopiclone is a drug used for the short-term treatment of insomnia.

The following day, an entry made in the prisoner's IMR suggested that he had settled in the healthcare centre and had not self-harmed since his admission. However, he had been responding to auditory hallucinations and had appeared frightened and agitated. During the next few days, the prisoner's sleep pattern varied. Further entries made in his IMR described him as being unsettled and frequently hearing voices.

During the afternoon of 13 March, the prisoner told a member of staff that he felt the way he did because he was being bullied. When questioned about this comment, he refused to elaborate. Later that afternoon, the prisoner told the same member of staff that he had lied when he said that he was being bullied.

On 15 March, the prisoner told a Healthcare Officer that he "felt as though he could self-harm this morning". He was told that he would see the doctor that afternoon. The doctor saw him as planned and decided to increase his prescription of Zopiclone

to 10mg by night. On 16 March, the prisoner seemed more cheerful and expressed no thoughts of self-harm. He remained concerned about his medication and asked if he could take something during the day. The prisoner asked to see the doctor again. The doctor saw him the following day and changed the prescription to 5mg Olanzapine by day and 7.5mg Zopiclone by night.

On 18 March, the prisoner attended the day centre for an auricular acupuncture for the first time. At the end of the session he felt extremely relaxed and asked to be considered for further treatment. The next day, he attended the day centre again, this time to take part in a cookery class which he seemed to enjoy. He appeared to be skilled in the subject and told the Occupational Therapist in charge of the class that he used to cook for himself at home. He mixed well with the other prisoners in the centre and repeated his desire for further acupuncture.

On 21 March, a further F2052SH case review was held in the healthcare centre. This was attended by a Charge Nurse, a Staff Nurse and a Prison Officer. The prisoner was also present. He told the team that he felt more settled and had not become agitated or felt suicidal for five days. It was decided that the F2052SH should remain open but that the frequency of observations of the prisoner could be reduced.

During the following week, the prisoner remained settled. His sleep pattern was stable and there were no notations in his IMR to suggest that he was still hearing voices. On 26 March, a further multi-disciplinary F2052SH case review took place. The prisoner was described as feeling a lot better. He asked to be returned to a wing. He also said that he regretted his act of self-harm and was concerned about its effect on his family. The F2052SH support plan required that he should have access to a RMN (registered mental nurse) if required and that he should not be returned to Acklington because of the risk of further self-harm if sent there. The F2052SH remained open but, at about 4:15pm, the prisoner was discharged from the healthcare centre to C Wing, where he was placed in a safer cell (a cell designed to minimise the risk of self-harm). A doctor wrote in the discharge report that the prisoner had settled very well and that there were no current causes for concern. The prisoner had discussed events at Acklington in which bullying had apparently been a factor. The doctor stressed that the prisoner was not to be returned to Acklington unless these issues were resolved. A follow-up outpatient appointment was scheduled for 2 April. Upon his arrival in C Wing, the prisoner was allocated to a shared cell with another prisoner with whom he got on well. It was noted in the F2052SH that the prisoner was to be moved to a different wing the following Monday (29 March). In fact the record shows that he was relocated to E Wing, where convicted prisoners are normally held, on 27 March.

On 30 March, the prisoner was seen again by a doctor, who recorded that he was still hearing voices that commented on his actions. The prisoner also had thoughts of hanging himself but resisted because of the effect this might have on his parents. The doctor thought that the prisoner was possibly showing an escalation of psychotic symptoms. He therefore decided to increase the dosage of Olanzapine to 10mg and to introduce 7.5mg Zopiclone to help the prisoner to sleep properly.

On 10 April, the prisoner's parents visited him again. Nothing untoward occurred during this visit.

During a multi-disciplinary F2052SH case review convened on 11 April, the prisoner again explained that he had cut his throat because he was being "wound up" by other prisoners. He told the team that he now felt better and wanted the F2052SH to be closed. The team decided not to close the document.

On 18 April, a further multi-disciplinary F2052SH case review took place. The prisoner was relaxed during the review and gave positive answers to the questions put to him. The team decided to close the F2052SH. The prisoner was told that, despite this decision, help and support would still be made available to him if he required it. The support plan in the F2052SH comprised the following headings: "staff support, Prison Chaplaincy and Prison Listeners". It did not set out specific measures for staff or for the prisoner to follow or achieve.

On 22 April, a doctor saw the prisoner again. He wrote in the IMR:

*"Objectively it was difficult to confirm paranoia. Felt that prisoners were talking about him. Claimed Olanzapine was not working. Try new medication."*

On 24 April, the Olanzapine prescription was replaced by 300mg Amisulpiride. This is an anti-psychotic drug used to treat acute and chronic schizophrenia in which there are symptoms such as delusions, hallucinations, and thought disorders.

On the same day, the prisoner's cellmate in E Wing rang the cell bell and alerted staff to the fact that the prisoner had been talking about hanging himself. A F2052SH was opened immediately. At 4:15pm, healthcare staff were consulted. The prisoner told a nurse that his medication was not working. The nurse noted that it had only just been changed. The prisoner asked to be admitted to the healthcare centre as he thought that it was quieter there than in E Wing and because he liked being there. The initial assessment by healthcare staff concluded that the prisoner could be managed on his wing until seen by a doctor the following morning. At 4:45pm, the prisoner was interviewed by wing staff. He told them that he was hearing voices that were telling him to self-harm. He was advised that support was available to him and that he should use his cell bell "if his thoughts got too bad". The prisoner was to be placed on the normal level of observation.

At about 3:00am the next day, the prisoner deliberately self-harmed in his cell by lacerating his throat with a razor blade. The wound was described by a doctor as being "a serious deep cut" and about 8cm long. The prisoner was seen by a nurse who applied steristrips and a dry dressing to the wound. The prisoner explained that he had done this because he had heard voices from Acklington telling him to self-harm. He was relocated to a safer cell in C Wing where he was observed regularly for the remainder of the night. At 8:50am on 25 April, he declined his breakfast and asked about his medication. He was told that he would be seen by a doctor later that morning. At 11:00am, he was seen by a doctor and admitted to M2-12, a shared cell in the healthcare centre. Entries made in his F2052SH show that thereafter he was observed about every 15 minutes until 2 May. Those entries do not describe what, if any, interaction took place between the staff who made the

observations and the prisoner himself. At 5:50pm, the duty Governor signed the F2052SH as part of an audit check.

On 27 April, a multi-disciplinary F2052SH case review was held in the healthcare centre. The prisoner told the team that he continued to hear voices and that this was the reason for the self-harm incident on 25 April. The review summary recorded that he seemed settled in the healthcare centre but that further attempts at suicide were possible in view of the nature of his illness. The F2052SH was to remain open. The support plan required that the prisoner was to receive psychiatric input, support from healthcare staff, probation staff and the chaplains, and Listeners. He was also to be placed on intermittent watch.

On 28 April, an entry made in the IMR records that the prisoner was "fine". He was disappointed that exercise was cancelled but he attended the library. The entry shows that it was considered that the prisoner was displaying no symptoms of mental illness and that no suicide or self-harm ideas were offered. The duty Governor signed the F2052SH on 28 and 29 April and again on 1 May.

On 2 May, a further case review took place. It was noted that the prisoner had settled during the previous week and that he had not experienced any further suicidal thoughts. It was therefore decided that the frequency of observations could be reduced but that the F2052SH should remain open. The support plan again listed a number of departments that would offer him support but no specific measures were listed. The F2052SH was signed by the duty Governor that afternoon.

On 3 and 4 May, the prisoner took part in association and attended education classes. His mood was described as pleasant and bright. He offered no ideas of self-harm or suicide. The duty Governor signed the F2052SH on both days.

During the afternoon of 5 May, the prisoner used the gymnasium. During the evening he took part in association and played snooker. The duty Governor signed the F2052SH that evening.

On 6 May, the prisoner's nursing care plan was evaluated, after which the following entry was made in the IMR:

*"Not generally offering psychotic symptoms but seems very preoccupied at times. No further self-harm since 25/4/04. Settled in HCC (healthcare centre). Wound healed."*

Later that day, the prisoner was described as settled. He took all his meals and took part in the full regime of the healthcare centre. However, on 7 May he was seen standing on his bed examining the light fitting in his cell. The record does not make clear whether this was regarded by staff as a precursor to a possible act of self-harm or what action was taken.

During the evening of 7 May, the prisoner told a member of staff that he "felt like topping himself". Once again, he explained that he was hearing voices from Acklington. He was advised to see the doctor the next morning and that staff would be available to talk to him during the night should he need help. This offer of support

was reinforced by the duty Governor who noted in the F2052SH that the matter was discussed with staff who were to continue to observe and assess the prisoner. Later that evening, he again complained that he was hearing voices that, he said, were coming to him from Acklington. The voices were giving him thoughts of self-harm. However, he said that he was expecting a visit from his parents the following day and that he did not wish to hurt himself or them by self-harming. He was again advised that it was open to him to use his cell bell at any time and to ask for psychological support. An entry made in the F2052SH showed that staff were to observe him carefully for the following two hours, and to commence intermittent observations if there were any further concerns. During the following two hours, no further entries were made in the F2052SH. However, at 10:00pm it was recorded that the prisoner was quiet and settled and that he said he felt alright. Two further entries were made in the F2052SH during that night: one at 3:00am and the other at 6:00am. Each entry recorded that he "appeared asleep".

At 8:55am on 8 May, the prisoner collected his medication and took breakfast. He told staff that he felt fine. At 10:50am he took exercise. During the afternoon he was visited by his parents. At 4:00pm he said that he felt much better for his visit. Thereafter, he remained settled for a number of days.

On 9 May, the F2052SH was stamped by the duty Governor.

During the morning of 10 May, the prisoner was seen by a Community Psychiatric Nurse (CPN) who assessed his mental health. The CPN recorded in the IMR that he reported feeling "ok" and much more comfortable in the healthcare centre. He appeared very relaxed and fully reactive and responsive. He was still hearing voices, but they were less intense and less intrusive. The prisoner claimed not to have any active plans or intent to self-harm. In the judgement of the CPN, The prisoner was not displaying any symptoms of psychosis. Neither was there any perceptual disturbance. He was fully orientated with regard to time and place. All the signs were that he was settled in the healthcare centre and was now eating and sleeping. The CPN concluded with a plan to review him in one month and advised that there should be regular input from a psychiatrist.

A note made in the F2052SH recorded that the prisoner was relaxed after this consultation. That afternoon he took part in education classes and appeared to enjoy the session. He took his tea meal. The F2052SH shows that he presented no ideas of self-harm or suicide.

The next day the prisoner took all his meals and his medication. He took part in education classes and appeared settled.

On 12 May, the prisoner was again described as settled, although he declined exercise in the afternoon, choosing instead to remain in his cell lying on his bed. He took exercise in the evening and afterwards appeared settled once again. The F2052SH was signed by the duty Governor both in the morning and in the afternoon.

On 14 May, a further F2052SH case review was held. The prisoner reaffirmed that he felt safe in the healthcare centre and that he had no thoughts of self-harm. He did, however, admit to feeling paranoid when he heard voices and explained that this

experience made him feel suicidal. He agreed to tell staff whenever he felt like hurting himself. The case review concluded that the F2052SH was to remain open. The support plan required that he should remain in the healthcare centre on normal observations. He was also to receive psychiatric input as well as support from healthcare, probation and chaplaincy staff. Listeners were also to be made available should he need their help. No specific measures were set for staff or for the prisoner to follow or achieve. He made a phone call to his parents at 6:42pm that day.

During the period 14 to 22 May, the prisoner took all meals, exercise, and association. He interacted normally with other prisoners. He gave no signs that he was contemplating suicide, or that he was hearing voices. The F2052SH was signed by the duty Governor each day. An entry was made in the IMR on 16 May indicating that the prisoner's mood was appropriate and that he was interacting with staff and peers in the healthcare centre. He had taken part in exercise and association.

On 19 May, a further entry in the IMR records that there was an absence of any ideation of self-harm or any symptoms of psychosis. On 20 May, yet another IMR entry shows that the prisoner had a settled day during which he mixed with other prisoners and took part in healthcare centre activities.

On either 20 or 21 May (the date shown in the IMR is not easily discernible), the psychiatrist saw the prisoner. He wrote in his record of the interview with him:

*"...complains of hearing voices most of the time. Transferred from prison to medical wing 3 weeks ago following DSH (deliberate self-harm) by cutting his throat. Said he was disturbed by voices of the man from Acklington who asked him to kill himself. So he inflicted wounds to his throat with a razor. His cellmate pressed the buzzer and help arrived. Since then he complains of hearing voices and lower mood. But the nursing staff haven't notified him to respond to voices or feeling low. Objectively, his appetite and sleep are alright. When I explained to him that change of medications will not be helpful he said "Now I feel as if I want to cut my throat". Later he asked for something to help him sleep. Objectively, there is no escalation of psychosis and I felt he was pressing for some kind of sedative pill.*

*Plan: 1. To continue current medication;  
2. Psychiatric nurse to monitor him closely for evidence of auditory hallucinations and sleep disturbance so that they can be treated if this was the case;  
3. Review again in 4 weeks' time."*

At 11:25am on 22 May, the prisoner made a telephone call to his parents. During the call, the prisoner's mother thought her son was "a bit down". She kept asking him if he was alright and he told her he was. She told him that she loved him and advised him to keep mixing with other prisoners. She told him to avoid having any morbid thoughts. After the prisoner signalled his agreement, the call came to an end. His father later told my investigator that after this phone call, he again telephoned the prison and spoke to a nurse because he and his wife were so worried about their son. The nurse told the prisoner's father that he was playing pool and that he had no concerns about him at that time. The nurse asked his father if he

would like to speak to his son but he did not do so because he was concerned to avoid making his son feel embarrassed that he was checking on him.

On the morning of 23 May, the prisoner took breakfast and his medication. The record shows that he made no complaints and that he was “quiet but pleasant when approached”. The duty Governor signed the F2052SH around midday. The prisoner declined exercise in the afternoon but gave no cause for concern. He slept through that night.

On the morning of 24 May, the prisoner once again took breakfast and his medication. The following entry was made in the IMR by the Community Psychiatric Nurse:

*“..... remains in HCC - attended rooms to review but was attending education - will attempt to review again.”*

A further entry was made in the IMR later that day:

*“ Fine today, no clear evidence of psychosis. No suicide or self-harm ideas offered.”*

An entry made in the F2052SH also records that no suicide or self-harm ideas were offered. At 5:00pm, an entry was made in the F2052SH. It records that the prisoner was “ok at tea-time whilst collecting his medication”.

No other entries were made in the prisoner’s IMR, F2052SH or core record to show what took place between 5:00pm and 8:00pm that evening.

At approximately 8:05pm, the prisoner’s cellmate returned to the cell at the end of the evening association period. An officer unlocked the cell door to let the cellmate in. The cellmate entered the cell and immediately saw the prisoner hanging from the window bars. He shouted to the officer who called for assistance and entered the cell himself. He found the prisoner suspended by a ligature fashioned from shoelaces tied to the window bars. The prisoner was in a sitting position with his feet touching the cell floor. The officer supported the prisoner’s body weight while he waited for other staff to arrive. A number of other staff soon arrived. Between them, they cut the ligature from the prisoner’s neck and laid him on the floor of the cell so that cardio-pulmonary resuscitation (CPR) could be applied. Resuscitation attempts were then started. No “heart-start” equipment (defibrillator) or oxygen was taken to the cell. Healthcare staff later told the investigators that this was because they had not been trained in its use.

Almost immediately, the Control Room called for an ambulance. A paramedic crew arrived at the scene at approximately 8:21pm and took over the task of administering CPR. At approximately 8:45pm, a prison doctor arrived at the scene and pronounced the prisoner dead.

The establishment’s incident log gives the impression that no senior manager attended the healthcare centre during or after the incident.

## **7. Observations**

## Overview

Before the prisoner was sentenced to imprisonment on 17 October 2003, he had already harmed himself whilst in the community, once in 2000, and again in 2002. He had also been a drug addict for a number of years. At a time when he was about to experience his first taste of imprisonment, he was not in good mental health. As the Probation Service predicted, the prisoner's likelihood of harming himself was realised on a number of occasions both at Durham and Acklington prior to his eventual death on 24 May the following year. The Prison Service's duty of care for the prisoner, and its responsibilities for the management of his mental health, were to be no mean task for the staff at both prisons.

The investigation into the prisoner's death has found that, notwithstanding the comments I make later in this section, there is much to commend in the way his mental health and risk of self-harm were managed during his time in custody. The prisoner was placed on a 10-day detoxification programme immediately after his arrival at Durham from court. Although the concerns expressed by the Probation Service about his vulnerability to self-harm were not available to reception staff on the day he arrived, he was made subject to self-harm monitoring procedures the next day after his parents told staff that he wanted to hang himself. Thereafter, further self-harm monitoring procedures were invoked on each of the occasions when he either threatened or carried out an act of self-harm. Regular multi-disciplinary case reviews were held. The prisoner was present at each review. The frequency of the observations to be made of the prisoner was appropriate to the risk of self-harm he presented. Decisions as to the timing of the cessation of the self-harm monitoring arrangements were justified. Effective communication between healthcare and wing staff was evident. Communication between medical staff at Acklington and their counterparts at Durham was equally effective. The prisoner was allocated to shared accommodation throughout his time in custody.

The prisoner clearly had some form of mental illness. The view of the medical and psychiatric staff was that he was most likely suffering from drug induced psychosis and/or schizophrenia. His mental health was consistently monitored at Durham and at Acklington. Appropriate medical and psychiatric interventions were made. The prisoner was admitted to the healthcare centre at times when he most needed close medical supervision. Nursing care plans were established and regularly reviewed. When the prisoner was discharged from the healthcare centre to a wing, there was good liaison between specialist and discipline staff.

When he was found hanging on 24 May 2004, staff responded quickly and, in very harrowing circumstances, made every effort to revive him using cardio-pulmonary resuscitation techniques. There was no undue delay either in calling for an ambulance or in the arrival of a paramedic crew at the scene. The prisoner's next of kin was informed of his death on the same day.

That said, the investigation has also revealed points of concern about some aspects of F2052SH procedures, the management of the incident, and issues about bullying. These are described below.

## **F2052SH procedures**

- **Quality control checks**

I am concerned that some of the F2052SH quality control checks carried out by duty Governors at Durham in respect of the prisoner were ineffective. It was not uncommon for them merely to use a stamp bearing their name and grade to indicate on the daily supervision and support page of the document that the F2052SH had been seen. The absence of any comments by duty Governors suggests that the system for auditing the document was a "tick-box" process. The fact that there was an audit system in place is commendable, but any system that does not require comments to be recorded about the level of care being given to prisoners is unsatisfactory.

- **Recording of observations**

In general terms, the comments made in the prisoner's F2052SH documents by staff who were responsible for observing him reflect an appropriate level of interaction with the prisoner. However, those entries made in his F2052SH between 25 April and 2 May 2004 do not describe what, if any, interaction took place. It is essential that entries made in Forms F2052SH do not become repetitive or banal. Audit checks should seek to prevent that possibility.

At 8:10pm on 7 May 2004, an entry made in the F2052SH required the prisoner to be observed carefully for the following two hours. No further entries were made in the document until after that two hour period had elapsed. Although it is clear from the next entry that was made (at 10:10pm), that the prisoner had settled, staff should have kept a contemporaneous record to show that the required observations had been made.

I am especially concerned that no entries were made in the prisoner's F2052SH between 5:00pm and 8:00pm on the day he died. The absence of any record of what, if any, observations were made during the last few hours of the prisoner's life raises questions about the level of care given to him at a critical time.

- **Case reviews and support plans**

In many instances, F2052SH support plans did not set out clear and specific measures for staff or the prisoner to achieve between case reviews. It is not sufficient for review panels merely to refer to a list of departments that might offer help to a prisoner if needed.

During the F2052SH case review held at Durham on 5 March 2004, no reference was made to a comment made by the prisoner during a telephone call with his parents on 22 February in which he said that he wanted to harm himself. It is essential that case review panels remind themselves of the recent history prisoners under review so that due account can be taken of significant events and situations.

- **Management of the incident**

The investigation has revealed that no “heart start” equipment (defibrillator) or oxygen was brought to the prisoner’s cell after he had been discovered hanging. It also became apparent that staff had not been trained in the use of the defibrillator. Although there is no evidence that the use of this equipment might have saved the prisoner’s life, its immediate availability at the scene of a potentially fatal incident for use by trained staff should nevertheless be the norm.

The establishment’s incident log gives the impression that no senior member of staff attended the healthcare centre during or after the incident. It is important for a senior manager to establish and maintain appropriate presence when a serious incident of this kind occurs. If, in the case of this particular tragedy, a senior manager was present in the healthcare centre, this fact should have been made clear in the log.

- **Bullying**

The investigation has revealed some evidence to suggest that there was friction between the prisoner and other prisoners.

On 26 December 2003, the prisoner was involved in a fight with another prisoner at Acklington. On 17 January 2004, he told staff at Acklington that he was under pressure from other prisoners but did not give any details that might have helped them to investigate his complaint. On 14 February, the prisoner was involved in a further fight at Acklington. At about the same time, he wrote letters to his parents in which he mentioned that he was being taunted by other prisoners. On 15 March, he told staff at Durham that he was being bullied but that the bullying was being perpetrated by somebody inside his head. He later told staff that he had been lying about this.

I am satisfied that staff at Acklington and Durham did all they could reasonably have been expected to do to help the prisoner whenever he felt under pressure from other prisoners. Although the prisoner told staff that he was under pressure from other prisoners, he yielded very little information that might have helped staff to investigate his complaints or to alleviate his fears. The Governor of Acklington commissioned an internal investigation into claims that the prisoner was being taunted by other prisoners. That investigation found no substantive evidence in support of those claims.

## **8. Recommendations**

### **1. F2052SH procedures**

The Governor of Durham should ensure that:

- **F2052SH audit checks carried out by duty Governors incorporate an examination of the interaction between staff and prisoners, the level of care shown to prisoners and the quality of entries made in the document;**
- **staff are reminded of the importance of making an accurate record of their observations of prisoners in forms F20502SH commensurate with the frequency of observations decided upon in each case;**
- **F2052SH support plans incorporate specific and measurable targets for staff and prisoners to achieve;**
- **staff who attend F2052SH case reviews are reminded of the need to study the recent history of prisoners under review so that due account is taken of significant events and situations.**

### **2. Emergency equipment**

**At any time that it is clear that a life-threatening incident has occurred in the prison, the emergency first aid equipment taken to the incident by staff responsible for responding should include oxygen and a defibrillator. The Governor of Durham should ensure that local contingency plans and instructions to medical staff, make this clear.**

**The Governor of Durham should ensure that appropriate staff are trained in the use of the defibrillator and other emergency medical equipment.**

### **3. Incident management**

**The Governor of Durham should remind his senior management team that an appropriate senior manager should be present as soon as possible after the apparent death of a prisoner has been discovered. This should be reflected in local contingency plans.**

### **4. Communication**

All agencies involved in the care of prisoners have a responsibility to actively help the Prison Service to care for those in its custody. Whilst the delay in sending the pre-sentence report did not have a direct bearing on this case, it could be of great importance in other situations. The concerns of the Probation Service in respect of The prisoner's potential for self-harm should have been communicated forthwith.

**I recommend that the Governor sends a copy of this report to the Chief Officer of the County Durham Probation Area drawing his attention to my comments on the need for probation staff to share information relating to self-harm or**

**suicidal ideation without delay. I further recommend that the NOMS Safer Custody Group sends a copy of this report to the National Probation Directorate for their consideration.**

At draft stage, the National Probation Service requested that the following response should be included in the final report:

“We fully accept the recommendation contained within the report. Policy and practice is to immediately fax post sentence information forms to the receiving prison where there is a risk of self harm or suicidal ideation. We will bring this to the attention of probation areas to ensure that all appropriate staff are reminded of the need to share information with the receiving prison without delay. We will also consider arrangements whereby an audit trail can be provided for such faxes sent and received.”