Investigation into the circumstances surrounding the death of a man at HMP Durham in June 2010

Report by the Prisons and Probation Ombudsman for England and Wales

June 2011

The man was found hanging in his cell in June 2010 at HMP Durham. He was 41 years old. I offer my sympathy and condolences to those affected by his death.

The investigation was carried out on my behalf by my colleague. A clinical review of the man's healthcare was undertaken by the clinical reviewer on behalf of the local Primary Care Trust. I would like to thank the Governor of Durham and his staff for their co-operation and assistance.

The man had been in prison a number of times before. He drank excessively and had been put on an alcohol detoxification programme. However, he died within four days of coming into prison on this occasion. It is very difficult to explain such a death, and I know that his family may find this hard to accept. He had not been thought to be at risk of harming himself and was withdrawing from alcohol but without any severe symptoms. On the morning of his death he was unsteady on his feet, and staff arranged to visit him after lunch to check whether he was any better. Unfortunately, he took his life before they arrived.

Alcohol detoxification can be very difficult for some prisoners. Aside from the physical symptoms, prisoners can realise the impact of their offences and drinking. This can particularly affect some prisoners, and it is important that staff look beyond the physical reactions of the people they are looking after. Resources for prisoners going through alcohol detoxification are pressed across the public sector. Nevertheless, I must mention what may well be an ongoing challenge for prisons across the country. The risks of suicide are heightened in this group of prisoners, and their mental and emotional, as well as physical, needs should be met.

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 **June 2011**

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SUMMARY

1. The man was born in November 1968. He was remanded into custody on 23 June 2010 due to charges relating to contact with his partner. He had been in prison before and had harmed himself before.

2. When he arrived at HMP Durham, his Person Escort Record (PER) identified him as at risk of suicide or harming himself. He was seen by a nurse in reception who asked about suicide and self harm. He denied that he had any thoughts of harming himself at that time. The nurse referred him to the mental health team and to the doctor for detoxification from alcohol. The doctor prescribed alcohol detoxification medication for him and asked staff to provide him with extra detoxification medication at midnight. The doctor also spoke to him about his history of harming himself. Once again, he denied having any thoughts of suicide although he admitted harming himself in the past. Following their meeting, the doctor did not consider that he was currently at risk of harming himself. The prison's suicide monitoring and support procedures were not put in place.

3. He was reviewed each day to check on his physical well-being. He initially had a cell-mate in his double cell, but the other prisoner was moved once he became a wing cleaner. In accordance with the local procedures, the safer custody team visited him on 25 June because of the warning signs of suicide and self-harm on his PER. He repeated that he had no plans to harm himself and no further action was taken.

4. Nursing staff reviewed him over the next few days and he continued with his alcohol detoxification treatment. He took his morning medication on 27 June without any concerns being raised. However, when he was reviewed approximately half an hour later, a healthcare support worker was concerned about his appearance. He seemed unsteady on his feet and complained of feeling unwell. The healthcare staff decided to review him again after lunch to check on his wellbeing.

5. He was found by an officer at 10.50am, having hung himself in his cell. Healthcare staff responded to the emergency, but were unable to resuscitate him. He was declared dead at 11.20am.

6. Durham did not have any trained family liaison officers (FLO) available at the time of his death. Instead they contacted a neighbouring prison and asked one of their FLOs to break the news on their behalf. The FLO assisted with the funeral arrangements and his property was returned to his family. His family raised a number of concerns with my investigator which I trust have been answered in the report.

7. I make four recommendations in this report about reception and family liaison procedures.

THE INVESTIGATION PROCESS

8. My colleague was appointed to lead the investigation on my behalf. On his initial visit to the prison, he met the Governor, police liaison officer and Head of the Care Team. They were also introduced to the Chairman of the Prison Officer's Association local branch and members of the Independent Monitoring Board. He was shown around E wing and the man's cell. Notices were issued to prisoners and staff to alert them to the investigation. In response to these notices, his former cellmate asked to speak to the investigator regarding the investigation.

9. The investigator wrote to the local Primary Care Trust (PCT) to request a review of the clinical care the man received while in prison custody. The clinical reviewer conducted the clinical review. She was provided with all of the relevant documentation and the transcripts of the interviews in order to assist in her report. The final review was received in late December.

10. One of my family liaison officers contacted the man's family to explain the investigation and offer to meet them. The investigator and family liaison officer met the family on 27 July. The family raised the following issues:

    - He had not been assessed as being at risk of harming himself
    - Whether the medication may have contributed to his decision to take his life.
    - The prison told them information that later turned out to be incorrect.
    - Whether there had been blood in the cell.
    - They were unhappy that they had not been warned about what they would see in the cell when they visited.

11. I have attempted to address these issues in my report, and hope that it provides the family with a better understanding of the time leading up to his death.

12. The investigator conducted interviews with ten prison staff and one prisoner on 26 and 27 July 2010. Following the interviews, the investigator fed back the interim findings of the investigation to the Governor's representative, and wrote to Durham's Governor outlining the interim findings. He also spoke to the investigating police officer regarding the family's concerns about the cell when they visited.

HMP DURHAM

13. HMP Durham is a Category B local prison built in the early 19th century. Prison Service Order (PSO) 0900 (Categorisation and Allocation) explains the reason for categorising prisoners:

> *"Prisoners must be categorised objectively according to the likelihood that they will seek to escape and the risk that they would pose should they do so*."

14. Category B prisoners are defined in the PSO as:

> "Prisoners for whom the very highest conditions of security are not necessary, but for whom escape must be made very difficult."

15. It serves courts in the north east of England and it holds just under 1,000 prisoners. The prison consists of seven wings as well as a segregation and healthcare unit. E wing, the induction wing, also serves as the stabilisation/detoxification wing and is staffed by nurses as well as officers.

Assessment, Care in Custody and Teamwork

16. Assessment, Care in Custody and Teamwork (ACCT) is a care planning tool used by the Prison Service to support and monitor those prisoners identified as being at risk of suicide or self harm. The ACCT process encourages staff to work together to provide individual care to prisoners in distress and help to diffuse circumstances where self harm or suicide may occur.

Person Escort Record

17. The Person Escort Record accompanies prisoners on all journeys from and between prisons, the courts and any other location such as a police station or hospital. It serves as a communication tool about any risks that a prisoner poses on escort or transfer and provides a chronological record of the journey.

Her Majesty's Chief Inspector of Prisons

18. The last inspection by Her Majesty's Chief Inspector of Prisons was in October 2009. The report commented:

> "Overall management of violence reduction and suicide prevention had improved considerably, but it was not clear that residential staff were fully engaged in, and properly implementing, these procedures. Nevertheless, most prisoners – including vulnerable prisoners – felt safe."

19. The report went on to say that a multi-disciplinary (staff from different departments) safer custody committee met monthly to discuss such matters, and the implementation of action plans following deaths in custody had

improved. The report also noted that alcohol detoxification treatment was offered to all who required it.

Independent Monitoring Board

20. Each prison has an Independent Monitoring Board (IMB) made up of members of the community. The Board's role is to ensure that the prison is properly run and that prisoners are treated decently. Each Board produces an annual report for the Secretary of State. The most recent annual report from the Durham IMB covers the period November 2007 to October 2008. The report noted the low number of ACCTs open at the time but said: "The variable quality of ACCT documentation is raised from time to time, but apart from this the prison is performing well, as evidenced by high audit markings."

Previous deaths at Durham

21. There were five self-inflicted deaths in the last two years, including another prisoner who was also undergoing detoxification from alcohol.

KEY EVENTS

22. The man arrived at HMP Durham on 23 June 2010 having been charged with a number of violent offences against his partner. The person escort record (PER) that accompanied him to prison contained the following note next to the suicide/self-harm risk box:

    "PNC [police national computer] markers for suicide attempts"

23. The PER also contained information that at 12.35pm (prior to arriving at Durham), escort staff had carried out a self-harm interview due to the indicators on the PER regarding previous suicide attempts. He said that he no thoughts of harming himself although he confirmed that he had attempted to hang himself years earlier.

24. When prisoners arrive at a new prison they go through the reception process. A number of interviews are undertaken to assess their physical and mental well-being, and initial needs. A cell sharing risk assessment is carried out by a prison officer to establish the level of risk a prisoner presents to a cellmate. He told Officer A that he had no concerns about sharing a cell, which he had done on previous occasions. He told the officer that he had problems with depression. No self-harm concerns were noted and he was judged to be low/medium risk of harming a cell-mate.

25. He underwent a first reception health screen with Nurse A. The nurse confirmed to the investigator that he did not have sight of the PER when he undertook the health screen. He told the nurse that he was a heavy drinker, and consumed 126 units a week. (The government guidelines are for a man to drink no more than three to four units a day.) The nurse assessed that he was showing signs of withdrawing from alcohol. He told the nurse that he was prescribed sleeping tablets and had seen a doctor in the last few months for depression. He also revealed that he had deliberately overdosed two months earlier which had resulted in him being admitted to a hospital intensive care unit (ICU), but he denied that he was currently considering harming himself. (When the clinical reviewer reviewed the records from his community doctor, there was no record either of him being prescribed anti-depressant medication or being admitted to an ICU following an overdose.)

26. The nurse referred him to the doctor, mental health team and substance misuse team. On the mental health referral, the nurse noted his history of depression and self-harm, and his stay in hospital following the overdose. The nurse explained to the investigator what would necessitate an urgent referral, where the prisoner could be seen the next day. Urgent referrals would include prisoners who were mentally unwell, psychotic or with a major mental health problem such as depression or actively suicidal. The nurse did not think that he presented with symptoms which required urgent attention.

27. No physical conditions were identified other than minor injuries from falling off a bike. The nurse judged him to be fit for any cell location and fit for work. His blood pressure was recorded as 147/90 with a pulse of 93 beats per

minute (130/80 is the optimal average blood pressure reading. A pulse between 60 and 100 bpm is within normal range.)

28. He saw Prison Doctor A following his referral from Nurse A because of his alcohol misuse problems and mental health issues. The appointment took place in an examination room on E wing. The doctor noted that, although he was not unwell, he exhibited a moderate tremor. He prescribed 40mg of Chlordiazepoxide (CDZ) to be taken now, to be repeated with a review at midnight. (CDZ is used to treat alcohol withdrawal.) (During interview with the investigator, the doctor said that the repeat dose was prescribed as he appeared to be withdrawing. It was not the doctor’s usual practice to prescribe an extra dosage at midnight.) He also prescribed thiamine and vitamins. He also requested that staff monitor him carefully as he had a history of fits during withdrawal. The doctor recorded his mental health issues including depression and that he had overdosed on sleeping tablets. He also told the doctor of his attempted hanging and overdose although he again said that he had no thoughts of harming himself at that time.

29. A substance misuse worker undertook a substance misuse assessment with him. He explained that during the past year he usually drank up to eight to twelve cans of strong lager upon waking, and a litre of vodka each evening. He confirmed that he last had a drink the previous day, and was now suffering from tremors and insomnia. He said that he had taken a deliberate overdose two months earlier that had resulted in him being admitted to hospital. It was also noted that he suffered from depression and that he had attempted to hang himself by a ligature five years previously. However, the substance misuse worker noted that he had no current thoughts of harming himself, and Assessment, Care in Custody and Teamwork (ACCT) procedures were not put in place.

30. He was allocated a double cell on the third floor of E wing, the induction unit. He continued the induction procedures the following day. The medical record reveals that the mental health team responded to the mental health referral and a routine appointment was made for 6 July. (An urgent appointment or an appointment within seven days could also have been arranged.) He also had an alcohol detoxification review meeting with two nurses where he outlined the level of his drinking. He denied blacking out or having fits and was recorded as being at level 2 on the alcohol withdrawal scale. (The Alcohol Withdrawal Scale is a tool used to measure the severity of withdrawal symptoms. Scores range from 0 to 30 with 0 being no symptoms and 30 being very high). His blood pressure was recorded as 126/79 with a pulse of 61 beats per minute (bpm).

31. Nurse B advised him to continue taking the CDZ medication and reminded him of the importance of taking thiamine and vitamins. She explained to the investigator that taking thiamine is important for prisoners undergoing alcohol detoxification. She described it as a type of vitamin which helps the brain function especially as they start to eat and the thiamine levels are depleted.

32. On 24 June, he handed in a learning and skills application form outlining his previous work experience. He also completed a prisoner's general application form on which he wrote that he would like to be considered for a cleaning job in the prison. This application is not dated.

33. The next day, 25 June, his cellmate left the cell as he had been given a job as a cleaner. (The wing cleaners live near each other and so the cellmate left the cell to join his colleagues on the second floor.) The two cellmates had got on well according to him and they continued to be friendly when they saw each other on the landing and at meal-times. He did not get a new cellmate during the remainder of his time at Durham. He was again reviewed by the alcohol detoxification nurse. Later that morning, his blood pressure was recorded as 131/79 with a pulse of 74 bpm. He was recorded as seven on the alcohol withdrawal scale.

34. In accordance with the local procedures at Durham, a member of the security department emailed the safer custody team on 24 June with the names of the prisoners that came to Durham with self-harm or violent markers noted on their PERs. He was included in this email and Officer B took a safer custody enquiry form and went to see him on 25 June. The officer was not aware of his previous comments regarding his recent attempt to overdose. The form recorded that the officer asked him about the markers on the PER. He told the officer that they referred to events years ago and he had no thoughts of harming himself at that time.

35. Due to his comments, the officer did not initiate any form of support, such as ACCT procedures. He told my investigator " … he just seemed bright, he didn't give any cause for concern." He told my investigator that the man was also getting support from the detoxification nurses. He signed the form indicating his consent with the decision taken.

36. He was reviewed again at 9.30am on 26 June by detoxification staff. He was recorded as six on the alcohol withdrawal scale, with a blood pressure of 112/77 and a pulse of 71 bpm. It was noted by Healthcare Support Worker (HCSW) A that he would continue to be monitored on the wing. (HCSWs carry out tasks under the supervision of qualified nursing staff.) Officer C was in the room when he was reviewed on 26 and 27 June. He recalled that:

> "He struggled from the bit I remember on the Saturday. He struggled, he didn't know what the date was or what month it was. He just seemed a bit obviously withdrawing from the alcohol misuse. He did seem quite unwell both days."

37. Officer D saw him at breakfast the next day, 27 June. The officer later told his colleagues that he had seemed in good spirits at the time, and gave him no cause for concern. He collected his detoxification medication from the medication hatch at approximately 8.30am. Nurse B recalled to the investigator that he had "seemed fine" at that point, and did not have any tremor in his hand when he held it out for the medication.

38. HCSW A reviewed him on the wing at 9.05am that morning. His blood pressure was recorded as 129/91 with a pulse of 81 bpm. She noted that he looked unsteady on his feet, with visible body tremors. (Officer C had told her that he had been unsteady on his feet the previous day as well.) He complained that he was still unable to sleep, and did not seem to know what day it was. She asked him how he was feeling, to which he answered “Not good.” She told my investigator that she became concerned about his presentation and so she telephoned Nurse B in the E wing pharmacy. The nurse confirmed to her that he had collected his prescribed medication that morning and no concerns were noted at that time.

39. During interview with the investigator, Nurse B confirmed that she had been in the room when he collected his morning medication and she had not noticed anything of concern about his appearance. She was surprised to hear that he seemed so poorly at the review at 9.05am given that around 30 minutes earlier he had come down from the third floor to the medication hatch without any apparent problems. She recalled that he had not had any tremor in his hand when he received his medication.

40. The nurse told the investigator that she was surprised that he had declined so quickly, and so she agreed to review him again after lunch. (This would have been an additional review over and above the usual schedule of reviews.)

41. Officer C told the investigator that, although he seemed unwell due to alcohol withdrawal, he was not concerned that he might harm himself:

> “He did seem unwell at the time. I’ve been in the job ten years and he didn’t seem as though he was going to commit suicide. … I thought he was unwell withdrawing from the alcohol but I didn’t think he was going go ahead and do what he did.”

42. At 10.50am, Officer D unlocked cell E3-28 for association (when prisoners have free time out of their cells) and saw him hanging by ligature from the bar on the top bunk of the bed. He told the investigator that he thought the ligature was made from a bed sheet or pillow case, and it was quite thin. (My investigator was told by the prison that the ligature was made from a bed sheet.)

43. The officer ran to the induction room, pressed the alarm bell and shouted for assistance because he was on the landing on his own. Officer E was in the room and responded to Officer D’s shout. Officer D asked Officer E to alert Hotel 1 to a hanging incident. (Hotel 1 is a call sign attached to a radio that is always carried by a member of the healthcare staff. The holder of the Hotel 1 radio is the first responder to any medical emergency situation in the prison.) The alarm was raised by means of a Code Black alert over the radio. (A Code Black alert means an emergency regarding a ligature.)

44. Officer D lifted the man and thought that there were signs that he was still alive as air left his body and there was a noise. He cut the ligature with his anti-ligature knife and Officer B and Officer E arrived in time to help lay him on

the floor. Cardio pulmonary resuscitation (CPR) was begun by Officer B and Officer E. Senior Officer (SO) Davidson arrived and also requested the attendance of Hotel 1. He asked the control room to request an ambulance.

45. Three nurses responded to the Hotel 1 alarm call and arrived and took over CPR. (Officer D told my investigator that, although it was hard to judge the timing, he thought the nurses arrived a minute or two later.) Two nurses continued CPR and the third nurse collected the oxygen cylinder, emergency bag and defibrillator. (A defibrillator is a machine that can restart the heart in certain situations.) The defibrillator was attached to him but it advised the staff not to administer an electric shock him to stimulate the heart but to continue CPR. The paramedics arrived and took over CPR. The attempts at resuscitation were ended at 11.15am, and a prison doctor confirmed the time of his death at 11.20am. Notices to staff and prisoners were issued at midday informing them of his death.

Contact with the man's family

46. The man had listed his father as his next of kin. Both of the prison's trained family liaison officers (FLOs) were on annual leave on 27 June. HMP Holme House was contacted at 11.50am to ask whether they could provide a FLO. At 12.20pm Holme House replied to say that they were unable to help as they had no cover for their own FLO. HMP Low Newton, HMP Frankland and HMPYOI Deerbolt were then all contacted regarding supplying a FLO cover. At 12.45pm a governor from Deerbolt offered the services of one of their FLOs. She arrived at 2.10pm and a governor was assigned to work alongside her. They left to break the news to the man's father. At 3.25pm the governor called the prison to say that the address provided was incorrect. The police were able to provide the correct address at 3.35pm. At 4.15pm the governor telephoned the prison to say that the family had been informed of his death.

47. The family visited the prison on 1 July and visited the man's cell. The prison contributed to the costs of the funeral. I will consider the appropriateness of the family liaison in the Issues section of the report.

Support for staff and prisoners

48. A hot debrief was held at 12.23pm, chaired by the duty governor. (This is a meeting of all the staff who were involved in finding and attempting to resuscitate the prisoner.) It allowed all the staff involved to discuss their involvement. The governor outlined all the avenues of support that staff could access including the Samaritans and the Care Team. Following the debrief, the governor saw each of the officers who responded to the emergency individually to check on their welfare. All of the staff involved assured the governor that they could remain on duty.

49. The investigator was told that the prisoners were informed of the man's death and offered Listener and chaplaincy support. (A Listener is a prisoner trained by the Samaritans to provide emotional support to other prisoners. It is confidential, but is not a counselling service.) The Listeners were informed of

the situation and made available to all prisoners. All the prisoners on the wing subject to ACCT monitoring procedures were reviewed. The man's cell-mate was told personally of the death and checked with regard to his welfare.

ISSUES

Clinical care

50. The local PCT commissioned a clinical reviewer as the clinical reviewer in this case. Her report can be found as the first annexe to my report. She assessed his overall physical care in the following manner:

> "The treatment that the man received for detoxification and his physical healthcare seems to have been appropriate."

Mental health support

51. When he arrived at Durham, he told staff that he had a history of attempting to harm himself, and had previously been prescribed anti-depressant medication. (As part of her review, the clinical reviewer requested his medical records from his community practice. The records are not consistent with his statements about his medical history. However, the prison had no way of knowing this as they did not have access to these records during his time in custody.)

52. During the initial healthscreen, Nurse A referred him to the mental health team. However, the clinical reviewer expressed concerns about the lack of detail on the referral:

> "It merely stated 'history of depression and self harm. Was in ITU [intensive treatment unit] after overdose'. The previous hanging attempt, the man's statement that his overdose was only two months ago, the fact that he was in Alcohol Detoxification and him saying that he was currently prescribed anti-depressants and sleeping tablets to which he did not have access until prescription could be confirmed by his GP was not mentioned."

53. The quality of information on documents is important, particularly when it is being passed to another department for action. The mental health team would have benefited from more information being included on the referral which would have helped them to assess his needs. The clinical reviewer makes two recommendations in her review regarding mental health referrals that I would encourage the Head of Healthcare to consider.

54. In addition to the lack of content in the referral, the clinical reviewer was also concerned about the lack of urgency of the referral. Nurse A had the option of grading the referral as routine (to be seen within 28 days), moderate (to be seen within 7 days) or urgent (to be seen within 48 hours). The Durham Cluster of Prisons Policy regarding 'Response Criteria for Referrals to Mental Health Teams' lists criteria for urgency of referral as follows:

> “**Routine**
> Those Service Users [meaning a prisoner] with intermittent episodes of mental health difficulties, who may have had no previous contact with services.
> **Moderate**
> Service Users with a severe and / or enduring mental health problem where there is an identifiable need for ongoing therapeutic intervention or those who are experiencing difficulties associated with their mental illness which is seriously affecting their quality of life or that of their carer. Failure to act would result in an increase in risk.
> **Urgent**
> The person’s lifestyle, behaviour or self-care presents an immediate serious threat to the health or safety of the individual (suicide, violence, serious neglect or abuse has occurred – there is an immediate risk to a vulnerable adult or others).”

55. The clinical reviewer wrote:

> “It is the opinion of the clinical reviewer that there was enough clinical information relayed by the man to warrant the referral being marked as urgent. … The referral to the Mental Health Team was not sufficiently completed and not marked as urgent and did not contain sufficient information for the receiver to ascertain that a more urgent assessment may have been required.”

56. During interview, Nurse A confirmed that he did not think the man was sufficiently unwell for the referral to be undertaken more urgently. He explained how he had presented during the healthscreen:

> “ … his non-verbal communication was fine, he had eye contact, he was answering the questions appropriately. I even remember one of the staff in the room making a comment on his unusual surname and he was talking about that. He was talking about when he was here in the 1990s how different it was and it was one huge, there wasn’t any toilets and stuff like that … I wouldn’t say he was withdrawn or anything like that.”

57. The nurse explained to my investigator the reasons that led him to make his clinical judgement on the grading of the mental health referral. Although the criteria for the urgency of the referral lists the types of factors that should influence the decision, it is not prescriptive and allows for a healthcare professional’s clinical judgement. People can fit into a number of categories and different professionals may come to a different view based on how the person presents.

58. Following the nurse’s account at interview, I am satisfied that he considered the urgency of the man’s mental health assessment and came to a reasonable conclusion, given the information at the time of the healthscreen. I think that the referral could have merited a moderate grading, but I am not persuaded that the evidence before the nurse necessitated an urgent referral.

(It should be noted that a moderate referral must take place within seven days, meaning that, even if this had happened, he may well have died before it could have taken place.) Therefore, I do not repeat the clinical reviewer's recommendation regarding the urgency of the referral in the investigation report.

Detoxification support

59. The clinical reviewer assessed the overall care given to the man during his detoxification treatment as appropriate, saying that:

> "The treatment that the man received for detoxification and his physical healthcare seems to have been appropriate."

60. He appeared relatively well on his arrival at Durham, but his physical condition declined as he continued to withdraw from alcohol. The clinical reviewer pointed out that:

> "The Durham Cluster of Prison's Policy for Alcohol Withdrawal advises that in the case of prisoners requiring detoxification and having a history of fits, or being at risk of suicide or self harm, that detoxification in the healthcare department, rather than on the wing, be considered."

61. However, she also reflects the following view:

> "The man was treated on E Wing which is staffed by nurses on a 24 hour basis. The Substance Misuse Nurse at the prison states that he was in 'minimum withdrawal' and that there were no clinical indications that meant he should be nursed in the healthcare department."

62. He did not exhibit significant withdrawal symptoms at the time of his arrival to the prison. Nevertheless, he was placed on the induction/detoxification wing where there is 24 hour healthcare support. He was reviewed daily and his clinical observations were recorded in his medical record. It is impossible to know if a different location would have made any difference to the actions taken by him. My own view is that he was correctly located in a wing with experienced officers and specialist healthcare staff.

63. The clinical records reveal that he was recorded on the alcohol withdrawal scale as two, seven, six and finally ten on the morning of his death. (The scale goes from 0 – 30 so it should be noted that ten is not a significantly high number compared to the level that the scale goes up to.) Staff monitored him everyday in accordance with the requirements and his clinical observations were within the normal range.

64. However, having appeared well when he collected his medication on the morning of 27 June, the HCSW thought that he was quite unwell when she reviewed him half an hour later. Following her concern, healthcare staff arranged for him to be further reviewed in the afternoon. Unfortunately he

took his life before the additional review could take place. The clinical reviewer noted:

> "No doctor was contacted when the man was seen to be experiencing confusion and unsteadiness on the morning of his death. It is acknowledged, however, that this may have been an option that may have been explored after the planned review which did not occur due to his death."

65. He appeared to have physically declined during the morning of 27 June and it appears that the healthcare staff viewed this simply as a physical problem. There is no record that they considered whether it could have indicated a decline in his mental or emotional health.

66. It has been my unfortunate responsibility to investigate the deaths of a number of prisoners undergoing alcohol detoxification. It can be a very vulnerable time for prisoners as, when they stop being dependent on alcohol, they can be confronted with a clearer realisation of the consequences of their drinking. This, coupled with the unpleasant physical effects of withdrawal, mean that alcohol detoxification is a particularly dangerous time for prisoners, especially those with a history of harming themselves. Unfortunately, national resources for such prisoners do not correspond with the risk prisoners undergoing detoxification for drugs present. I have written before about the need for prisoners on alcohol detoxification to be supported by a wider psycho-social monitoring plan.

Emergency response

67. Following the discovery of him hanging, several officers and healthcare staff responded and attempted to resuscitate him. The clinical reviewer said:

> "The actions taken by wing and healthcare staff when he was found, having harmed himself in his cell, appear to have been carried out correctly, swiftly and professionally."

68. Staff responded quickly to the finding of him and the investigation has uncovered nothing of concern in the resuscitation attempt. I agree with the finding of the clinical reviewer.

Record keeping

69. The clinical reviewer said, with regard to record keeping, that:

> "The clinical records do not consistently show the time clinical entries were made by individual nurses. Nor was it possible to identify the professional designation of the individual nurse making an entry. This is not in accordance with professional codes of practice."

70. Accurate and detailed record keeping is important in a custodial setting, and this is also true in a healthcare capacity. The clinical reviewer made the following recommendation, which I endorse:

The Head of Healthcare should ensure that an audit of record keeping checking healthcare staff's compliance with Nursing and Midwifery Council professional standards takes place and the outcomes are acted upon.

Whether the man was at risk of harming himself?

71. The man arrived at Durham with a number of risk factors:

- he was withdrawing from alcohol,
- he had a history of depression,
- he said that he had previously attempted suicide,
- his alleged offence was against his partner, and;
- he was also facing a possible custodial sentence.

72. None of these factors alone might have been significant but, taken as a whole, they might have indicated that he was at risk and should have warranted serious consideration as to whether he required further monitoring. However, he – despite all of the factors outlined above – appeared to settle into life in prison.

73. An Annex to Prison Service Order (PSO) 2700 (Suicide Prevention and Self-Harm Management) includes the sentence:

> "In the event of any incident of self-harm or whenever a member of staff believes a prisoner is at risk of suicide or self-harm, they must (where there is not one open already) open an ACCT Plan."

74. I am careful not to apply hindsight in my investigations. However, in the light of the family's concerns, it is important to evaluate, following the man's death, whether any signs were missed that could have prevented his death.

The information on the man's prisoner escort record

75. Although not all the prison staff would have been immediately aware of all of the risk factors outlined above, one issue should have immediately prompted consideration by staff. He came to Durham with a Person Escort Record (PER) that contained the following note next to the suicide/self-harm risk box:

> "PNC [police national computer] markers for suicide attempts"

76. The Person Escort Record (PER) is a document which is individual to each prisoner held in custody by the police, courts, escort services and the Prison Service. It is a standard form used by all the agencies which are responsible for transferring prisoners. It is a contemporaneous record of the external

movements of each individual prisoner between these different agencies. Prison Service Order 1025 states:

> "If a prisoner is received from the police with this box [suicide/self-harm] ticked staff must establish whether the risk is current or past."

77. The PER that arrived with him was ticked in the 'suicide/self-harm' box, with the above reference to the PNC markers. The task for the prison staff was, as the PSO makes clear, to ascertain whether the risk noted was accurate at the time that he arrived at Durham.

78. Durham staff did explore the self harm and suicide issues with him as a result of the information on the PER. They judged that his presentation and demeanour in interview was such that he was assessed as stable and not suicidal. He was seen by reception officers and also by Nurse A and prison doctor. Both healthcare professionals were aware of his history of depression and of harming himself, although the nurse told the investigator that he had not seen the PER. However, following their meeting with him, they assessed that he was not at risk of harming himself at that time. The nurse, during interview, explained to my investigator why he did not view him to be at risk of harming himself:

> " … I wouldn't say he was withdrawn or anything like that … I did think it was important he saw the doctor and the detox team the following day and the mental health team at some stage. But I really didn't feel he needed an ACCT document."

79. PSO 1025 also requires:

> "Staff should note that it is now a requirement to indicate both a current risk of suicide or self-harm and any known past risk. It is now however only a requirement that an F2052SH[1] is opened if there is a current risk."

80. The responses given by the man on his first night indicate why staff did not deem that the tick on the PER related to a current risk of self harm, and therefore explain why they did not begin ACCT procedures. I am satisfied that the nurse discharged his responsibility to ask about his risk of harming himself, and made his judgement accordingly. However, I believe that his assessment would have benefited from having a copy of the PER available to him when he undertook it given the warning signs ticked on it.

81. Paragraph 3.2 of PSO 2700 "Suicide and self harm" requires:

> "Reception staff must alert appropriate staff in the prison to any risks identified on the PER, eg healthcare and security staff, duty governor/orderly officer."

[1] The F2052SH system was formerly the Prison Service's procedures for dealing with prisoners at risk of self-harm or suicide. It has now been replaced by the ACCT process.

82. The cell sharing risk assessment may have referred to the PER's warning markers but it did not repeat all of the information on the PER. Although it may have made no difference to the nurse's assessment of him because he was told of his history of harming himself, this would not necessarily be so in every case. It was a missed opportunity for the relevant staff to have all the details to hand before they undertake a crucially important interaction with a prisoner.

The Governor should ensure that the PER (or a copy) is provided to staff undertaking the first reception healthscreen.

The man's safer custody meeting on 25 June

83. The Safer Custody Team at Durham is emailed with the details of any prisoners who have arrived with violent or self-harm warning ticks on their PERs. They then visit the prisoner to check if they have any immediate needs. This is not a mandatory requirement for prisons and goes beyond what they are required to do.

84. Officer B from the Safer Custody Team visited the man on 25 June following an email sent from the security team regarding the notes on the PER. The officer asked whether the markers referred to historical or current issues:

> "I spoke to him and I said obviously on the back sheet of that there's markers for suicide and its '99 I seemed to remember. When I'd spoken to him he was quite blasé about it and no, no that was years ago. I've never had feelings like that for years, don't worry, I mean I have documented that it was years ago. He was quite happy, he was smiling. There was no sort of reason to suspect anything. I had told him what I was writing on the form to say that he'd actually said it was years ago. He agreed with that and he subsequently signed the form."

85. As he denied any thoughts of suicide or harming himself and, more importantly, appeared bright and smiling, the officer did not deem there to be any reason to begin ACCT procedures. The Safer Custody Team being alerted to any prisoner who enters the prison with relevant information on the PER is good practice, and provides solid back-up to the judgements made at reception a day or two earlier. It is an example of good practice which the prison should be commended for.

Alerting the Safer Custody Team to prisoners with relevant information on the PER is an example of good practice.

86. The officer told the investigator that he would not routinely check the man's file for further information about his history and he did not volunteer any information to him about his supposed history of depression or suicide attempts. I think that checking the appropriate paperwork beforehand would be an additional and valuable asset to their meetings, and would develop their practice and enable staff to make a more informed judgement on the person

concerned. The Governor may wish to consider asking the Safer Custody team to review the prisoner's files before each safer custody review meeting.

87. However, it should be noted that a lot of the information regarding his history (excepting the PER) was in his medical record. He only spoke in any detail about his history of harming himself to healthcare staff (and in any event his information was not correct). The officer would not have had access to information in a prisoner's clinical record. My investigator was told by the Governor when he opened the investigation that he has since put in place measures to ensure that relevant information is shared between healthcare staff and officers. I understand that the healthcare department has been asked to inform the safer custody team (and mental health team if necessary) of any relevant self-harm information that they hold on their systems. I am pleased to hear of this initiative and encourage the Governor to continue this work.

Presence of a cellmate

88. PSO 2700 states:

> "Cell-sharing is a known protective factor against suicide. … The doubling-up of an at-risk prisoner with a cellmate can help to reduce feelings of loneliness and provide both with someone to talk to. Cellmates can also inform staff if they are particularly worried about their companion."

89. He initially shared a cell with another prisoner. They both applied to be wing cleaners but it was his cellmate who got the job and had to move out of the cell. Since Durham did not consider him to be at risk of harming himself, they did not seek to find him a new cellmate immediately. However, given that he was undergoing alcohol detoxification treatment – an inherently difficult time with raised self-harm risks - it may have been sensible to seek to do so sooner rather than later. A cellmate could have provided further support to him and alerted staff to any serious decline in his physical or mental wellbeing. However, it should also be acknowledged that it can be difficult for a prisoner to share with someone when they detoxifying, particularly in the early days of custody on an induction unit, when they too are adjusting to prison life.

90. To conclude, as I have identified, he did have a number of risk factors upon his arrival at Durham. However, even if the staff involved had been aware of each factor, professional judgement is still required to assess the particular risk a person presents at a specific time. His presentation appeared relatively balanced throughout his time at Durham and he denied any thoughts of suicide. I consider that the protocol which resulted in the safer custody team visiting him was a positive approach to try to identify and support prisoner who might be at risk, and I believe that staff did try to assess his needs appropriately.

Liaison with the man’s family

The unavailability of family liaison officers

91. When he died, the prison’s two family liaison officers were both on annual leave. Given that PSO 2710 (Follow up to deaths in custody) requires the prison to appoint both a family liaison officer and a deputy to cover any absences, there were clearly an insufficient number of family liaison officers at Durham and it is unfortunate that they both took leave at the same time. It is essential that the Governor arranges for a suitable pool of family liaison officers to be trained and ready for deployment. I understand that further staff have been identified to be trained as family liaison officers but nevertheless make the following recommendation:

    The Governor must ensure that he has sufficient trained family liaison officers taking into account leave, sickness and other commitments.

92. Despite this, I was pleased to hear that Durham responded to the problem in a proactive manner. Other prisons in the area were contacted, and Deerbolt agreed to provide a family liaison officer. This is in accordance with guidance in PSO 2710 which states that:

    > “The Family Liaison Officer may be from the establishment where the prisoner has died or from elsewhere within the area (or, if the family lives some way away, from another area).”

93. This family liaison officer, together with a governor from Durham, visited the family and broke the news of the man’s death. Obtaining a family liaison officer from another prison was a good decision by Durham as it enabled them to send both a member of staff trained in bereavement, and a governor able to speak about the specific circumstances of the death at Durham.

The initial meeting with the family

94. The family told my investigator that, while contact with the prison was reasonable, they were upset that certain information they were told on the initial visit later turned out to be incorrect. Specifically, the timing of his meetings with healthcare staff were not accurately recounted, according to his family. I think that these were probably innocent mistakes, and the prison staff were merely attempting to provide sought after information to the family. However, this highlights how sensitive such conversations are, and I would remind the Governor that providing accurate information in such conversations is of paramount importance.

The man’s family’s visit to his cell

95. The man’s family were invited to visit his cell. This suggestion is recommended practice in PSO 2710. They visited his cell on 1 July and told my investigator that they were shocked by what they saw. The cell was exactly as it was when staff attempted to resuscitate him. The television was

still on, medical equipment was scattered over the floor and his glasses were on the bed. They told the investigator that, had they known what they were going to see, they might have chosen not to visit the cell.

96. I do not think it inappropriate for Durham to leave the cell exactly as it was at the time of the prisoner's death. Had they cleaned and tidied it, it would have been impossible to return the cell to its original state should his family have preferred to see it in that way.

97. However, I think that the prison should have talked to the family and asked whether they would like to see it in the state after the resuscitation attempt or whether they preferred it to be cleaned and tidied. PSO 2710 states:

> "When the family attend the prison it is good practice to meet them at the gate and escort them, letting them know what they can expect to see. Explain what security arrangements are in place and why they are necessary."

98. The family said to my investigator that they were told the cell was still in its original state only when they reached the door of the cell. This is too late in my opinion and offered no realistic chance for the family to change their mind or to clean the cell should it be requested by the family.

The Governor should ensure that, when a bereaved family is given the opportunity to look around the prison, they are told well in advance what to expect, in accordance with PSO 2710.

99. The family also told my investigator that they were shocked by how much blood was in the cell. My investigator had been in the cell a few hours before the family visited and, when asked by the family, did not recollect a lot of blood. He asked the prison whether staff involved in the attempted resuscitation of the man had noticed the blood. They confirmed that they were not aware of large amounts of blood in the cell.

100. My investigator also spoke to the senior investigating police officer. She said that she recalled that there had been some blood in the cell, which she believed had been caused by tubes inserted by the paramedics when they attempted to resuscitate him. Such practice is common in resuscitations and, the post-mortem report made no reference to any other injuries that could have resulted in significant bleeding. I believe that the blood seen by his family must have been as a result of the resuscitation attempts.

Press articles

101. The family told my investigator that, following his death, they had been upset by certain articles that had appeared in the local press. The family said that the articles went into detail regarding his alleged offences and included unproven information. They said that the articles included reference to a prison spokesman, inferring that Durham had officially released such information to the press. My investigator spoke to the prison who confirmed

that they had not released any information to the press. My investigator has already informed the Governor of this matter, and I am sure he will wish to consider its implications in any further deaths in custody.

CONCLUSION

102. I have found that staff at Durham took the man's history of harming himself seriously. He had a number of risk factors, such as alcohol dependence, all of which were assessed and treated. Although it is clear with hindsight that the ACCT support might have been of benefit to him, I do not consider that staff acted unreasonably, given the information they had at the time. It should be remembered that, unfortunately, although ACCT procedures are a huge asset in the effort to safeguard prisoners, they are not a guarantee of safety. The Ombudsman's office has, sadly, investigated the deaths of many prisoners who took their lives while subject to ACCT monitoring procedures. There were a number of meaningful interactions by both healthcare and discipline staff who sought to assess the needs of the man. However, Durham's processes could be improved further by giving staff involved in the assessment of prisoners' risk greater access to relevant documents.

103. He clearly declined physically during his time at Durham, but it seems that this did not prompt any further consideration of his level of risk to himself. He had been referred to the mental health team but died before this could take place. The increasing demands of his detoxification from alcohol and the isolation he may felt from staying in his cell on his own could have been factors in his actions. As I have written before in other reports, alcohol detoxification is a very difficult time and inherently increases the risk of a prisoner taking his life. Identifying and supporting such prisoners should continue to be a priority for prisons such as Durham.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that an audit of record keeping checking healthcare staff's compliance with Nursing and Midwifery Council professional standards takes place and the outcomes are acted upon.

   This recommendation was accepted:

   "Healthcare staff reminded of CDDCHS Clinical record keeping policy and how to access it. Cascaded to staff via email Nov & Dec 2010. Care UK now have a monthly schedule identifying audit requirements."

2. The Governor should ensure that the PER (or a copy) is provided to staff undertaking the first reception healthscreen.

   This recommendation was accepted:

   **"The procedure for dealing with the PER form is in place.
   All PERs and any CSRA alerts, are located in a box file which is collected by the healthcare nurse and checked when the person is processed through the reception healthcare rooms. The only exception to this procedure is if the prisoner is a return, then any acts of self harm or concerns would be handed oven on a warning form from the escorting service i.e. G4S."**

3. The Governor must ensure that he has sufficient trained family liaison officers taking into account leave, sickness and other commitments.

   This recommendation was accepted:

   "A further 2 Family Liaison Officers completed training in Feb 2011and are now on rota."

4. The Governor should ensure that, when a bereaved family is given the opportunity to look around the prison, they are told well in advance what to expect, in accordance with PSO 2710.

   This recommendation was accepted:

   "*Safer Custody staff and Family Liaison Officers who may come into contact with bereaved families visiting the establishment have been briefed with regard to the following [above]."*

GOOD PRACTICE

1. Alerting the Safer Custody Team to prisoners with relevant information on the PER is an example of good practice.