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A Report by the  
Prisons and  
Probation  
Ombudsman  
Nigel Newcomen CBE

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**Investigation into the death of a man on 11 July 2012  
at HMP Holme House**

## ***Our Vision***

*'To be a leading, independent investigatory body,  
a model to others, that makes a significant contribution to  
safer, fairer custody and offender supervision'*

This is the report of an investigation into the death of a prisoner at HMP Holme House who died on 11 July 2012. The preliminary post-mortem examination concluded the cause of death was incised wounds to the neck. He was 39 years old. I offer my condolences to the man's family and friends.

The investigation was carried out by one of my investigators. A doctor was commissioned by NHS County Durham to review the man's clinical care at Holme House. Holme House cooperated fully with the investigation.

The man had been released from a prison sentence early in March 2012, but was recalled to custody on 28 March, for breaching the conditions of his licence. He was initially held at HMP Durham and later transferred to Holme House. Due to concerns about his mental health, the man was referred to the mental health team at Holme House. A consultant psychiatrist advised treatment with anti-psychotic medication but required further information about the man's health history before going ahead with this. Information from the man's community health record was received, but not reviewed by the mental health team, and the treatment never started.

On 8 July, his cellmate told an officer that the man seemed paranoid and he was concerned about his mental health. The officer did not think that there was anything to indicate that the man was at risk of suicide and self-harm or needed to see someone from the mental health team urgently, and completed a routine mental health referral. Three days later, on 11 July, the man was found dead in his cell with apparently self-inflicted wounds to his neck.

The clinical review concludes that the man's clinical care was generally equivalent to that which he could have expected in the community. However, I agree with the clinical reviewer that the failure to begin the treatment advised by the consultant psychiatrist was not in line with the standard that would have been expected in the community. This investigation also identified some areas for improvement including the need for more effective sharing of clinical information and a need to ensure that all known risk factors are fully taken into account when assessing a prisoner's risk of harm to himself.

The recommendations made in the draft report have been accepted by HMP Holme House. I have included the prison's response to the recommendations at the end of this report.

The 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.

**Nigel Newcomen CBE**  
**Prisons and Probation Ombudsman**

**March 2013**

## SUMMARY

1. The man died on 11 July 2012 at HMP Holme House. He was found in his cell with apparent self-inflicted injuries to his neck. His cellmate was not present at the time. The man was 39 years old.
2. The man had been released from HMP Northumberland on 6 March 2012, but was recalled to custody on 28 March, when his licence was revoked. He went to HMP Durham and transferred to HMP Holme House on 30 April.
3. At a health screen at Holme House, it was recorded that the man had a history of epilepsy and alcohol abuse. He said he had used drugs in the previous month and had a history of methadone misuse. He reported that he had previously self-harmed, but not for over two years. The man said that he had no intention to harm himself. The substance misuse team drew up a care plan for him later that day.
4. On 7 June, a consultant psychiatrist saw the man and concluded that he had quite severe impairment of his short term memory, most likely due to alcohol abuse. The man said he had been hearing voices, and the consultant noted that this was consistent with abuse of alcohol but could also be related to epilepsy. The consultant psychiatrist advised a trial of anti-psychotic medication, but the man's past medical history of epilepsy needed to be checked first. Although a summary of the man's community health records had been received by the prison, they do not appear to have been seen by the mental health team and the medication advised by the consultant psychiatrist was not prescribed.
5. During the afternoon of 8 July, the man's cellmate raised concerns about his mental health. The officer who saw the man told us that he appeared paranoid and believed that listening devices had been planted in his cell. She did not consider he needed to see someone from the mental health team urgently, but made a referral for him to be seen in due course. The officer did not believe that the man was at risk of suicide and self-harm.
6. Not long after 11.00am on 11 July, an officer unlocked the man's cell for him to collect his medication. The cell was covered in blood and the man had a very large cut to his throat. The officer called for assistance and healthcare staff attended but it was apparent that he had been dead for sometime. A prison doctor confirmed death at 11.18am.
7. The clinical reviewer considered that the man's overall quality of care was generally equivalent to community care, except that there was a failure to consider the treatment advised by the consultant psychiatrist. Although it would have been difficult to foresee the man's death we consider that more consideration should have been given to the wider risks and triggers he presented. We make five recommendations.

## THE INVESTIGATION PROCESS

8. The Ombudsman was informed of the man's death on 11 July 2012. The investigator issued notices to staff and prisoners at Holme House informing them of the investigation and asking anyone who had relevant information to contact him. One prisoner asked to be seen but was released before this was possible and did not respond to correspondence. The investigator examined all the man's relevant prison records, including his medical records.
9. NHS County Durham commissioned a doctor to carry out a review of the man's clinical care at the prison, to establish whether it was comparable with that in the community and to identify any learning points.
10. The investigator visited Holme House on 17 July, and spoke to the Governor and staff involved in the man's care. He returned to Holme House on 2, 3 and 19 October to conduct interviews. Initial feedback was given to the Head of Residence and Safety, on 19 October, and was subsequently confirmed in writing.
11. Her Majesty's Coroner was informed of the investigation. The Coroner gave the initial cause of death as incised wounds to the neck. A copy of this report has been sent to the Coroner.
12. One of our family liaison officers contacted the man's family. She outlined the purpose of the investigation and gave them the opportunity to identify issues for the investigation to consider. The man's family were positive about the support they received from the prison after his death, but raised the following:
  - They were concerned that no action was taken on information about previous self-harm when the man arrived at Holme House and subsequently relevant support may not have been available.
  - They were concerned at how the man was able to cut his throat from the front and queried whether anyone else was involved.
  - They knew the man was becoming increasingly paranoid and wanted to know what medication the man was receiving as he had been taking anti-depressants in the community.

The man's family received a copy of the draft report. No further representations were made in response to the findings.

## **HMP HOLME HOUSE**

13. Holme House, near Stockton-on-Tees, is a local prison primarily serving the communities of the Tees Valley, South West Durham, East Durham and North Yorkshire. It holds up to 1212 prisoners with a mixture of young adult offenders and adult males on remand or sentenced. Healthcare services are commissioned by NHS County Durham and provided by Care UK.
14. The man lived on Houseblock 3 (HB3) a vulnerable prisoner unit with a maximum capacity of 183 beds. Vulnerable prisoners are those who need protection from other prisoners for a range of reasons, including that the nature of their crime makes them targets for victimisation.

## **HM Inspectorate of Prisons (HMIP)**

15. HMIP last published inspection report of Holme House is of an inspection in July 2010. The report described Holme House as a challenging prison to run. Inspectors noted that, in many areas, the experience and the perception of vulnerable prisoners on Houseblock 3 were not as good as for prisoners elsewhere, but that relationships between staff and prisoners were good. The report noted that healthcare services had been modernised and were improving. Resuscitation equipment was available in healthcare and on each houseblock and checked weekly. Health services staff were resuscitation trained and up to date. Inspectors found no problem with prisoners accessing hospital appointments in the community.
16. The report also noted that the self-harm and suicide strategy was cohesive and comprehensive. Monitoring and analysis of information was described as basic but good and ongoing attention was paid to recommendations from death in custody reports. Levels of self-harm and the number of prisoners on open assessment, care in custody and teamwork (ACCT) documentation were regarded as relatively low.

## **Independent Monitoring Board (IMB)**

17. Each prison has an Independent Monitoring Board of unpaid volunteers from the local community who monitor all aspects of prison life to help ensure that proper standards of care and decency are maintained. The most recent IMB annual report for Holme House covers the period from January to December 2011.
18. The Board said the prison was well managed and that prisoners were treated with respect. However, the Board were concerned about the way the transfer of healthcare to Care UK in April 2011 was handled, particularly in relation to staff welfare and the impact on patients. Many prisoners had had their prescriptions altered or withdrawn during a review by the new provider. The Board commented that at one time there were over 50 complaints about healthcare awaiting reply, but also that staff deserved credit for maintaining a good level of service during a time of considerable change.

## **Assessment, Care in Custody and Teamwork (ACCT)**

19. ACCT is the Prison Service process for supporting and monitoring prisoners at risk of harming themselves. An ACCT plan can be opened by anyone working in the prison. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of observations and interactions are set according to the perceived risk of harm. Part of the ACCT process involves drawing up a Caremap to identify the prisoner's most urgent and pressing issues, set goals to help resolve the issues and identify who is responsible. The ACCT plan should not be closed until all of the actions on the Caremap have been completed.

## **Previous deaths at Holme House**

20. In the two years before the man died, there were three other self-inflicted deaths and six deaths from natural causes at Holme House. We have previously made a recommendation about opening of suicide and self-harm monitoring plans.

## KEY EVENTS

21. The man was born in 1973. He was 39 years old when he died on 11 July 2012 at HMP Holme House.
22. On 6 September 2011, the man was remanded into custody and went to HMP Durham. This was not his first time in prison. At Durham, the man was treated with chlorazepoxide for medical detoxification from alcohol. He was noted to have previously attempted suicide in the community and in custody (including hanging, overdose and cutting his wrists) but had not self-harmed for over two years. He was treated for depression but was not regarded as at risk of self-harm. He was prescribed medication to control epileptic seizures and for back pain.
23. On 13 December, the man transferred to HMP Acklington (now merged with HMYOI Castington to become HMP Northumberland). He was referred to the mental health team and said he suffered from sleep disturbance because of recurring nightmares, feeling of paranoia and hearing voices since his move from Durham. He believed other prisoners were talking about him because of a previous conviction of indecent assault and he said his nightmares related to a serious attack which resulted in his hospitalisation (we have not been able to confirm this information). The man said that one of the voices he heard was that of his friend who died in his arms. On 6 March, the man was released on licence from Acklington. Just over three weeks later, on 28 March, the man was returned to custody after appearing at the local magistrates' court for breaching his licence conditions. He arrived at HMP Durham the same day.
24. At a health screen on 28 March, it was recorded that the man had used drugs in the past and had a history of alcohol abuse, although he said he had not had a drink for two weeks. He was recorded to suffer from back pain and acne, for which he had been receiving treatment. He had mental health problems and it was noted that he had tried to hang himself in 2011, but no further details about this were recorded. The man said he was not suicidal. He was referred to the IDTS team (Integrated Drug Treatment System<sup>1</sup>) to be observed for signs of withdrawal.
25. On 29 March, the man had a second health screen when it was recorded that he had a history of alcohol abuse (drinking nine litres of cider and a quarter of a litre of vodka a day) and took illicit Subutex (buprenorphine, a semi-synthetic opioid.) He had a previous head injury and suffered from related seizures, which the man said were not alcohol related. Later that day a prison doctor saw the man and recorded that since a head injury eight years previously the man had seizures about every one or two months. He also noted that the man drank several litres of cider every day and sometimes took his prescribed dihydrocodeine with illicit Subutex. The man said he had been hearing voices since a friend died, which was the reason he took anti-depressants. He was

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<sup>1</sup>The Integrated Drug Treatment system aims to increase the volume and quality of substance misuse treatment available to prisoners, with particular emphasis on early custody; improved integration between clinical and CARAT services; and reinforcing continuity of care between prison and the community.

also on gabapentin, after nerve damage to his leg, apparently due to a dog bite. A prison doctor diagnosed opioid type drug dependence and alcohol dependence syndrome and prescribed methadone to treat pain and his drug addiction. A prescription for gabapentin was continued but the prison doctor noted that dihydrocodeine was not to be prescribed. He recorded that a mental health review was necessary to assess whether the man needed anti-psychotic medication.

26. On 29 March, the Safer Custody Department at Durham was informed that the custody liaison information record from the local magistrates court indicated that the man might be at risk of self-harm or suicide. The next day, 30 March, a mental health nurse assessed the man and recorded that the man said he was low in mood, in pain, suffering from poor sleep due to flashbacks from when he was assaulted and was hearing the voice of his friend who had died four years previously. He said the voice came from inside his head and said "come with me, come and join me". The mental health nurse suggested that these were likely to be his own thoughts rather than hallucinations. The man said he did not have any thoughts of suicide. The mental health nurse decided that he did not need mental health team support and advised him to discuss his concerns with the prison doctor.
27. During the following days the man was regularly observed by healthcare staff as part of the detoxification process. There was no evidence of any problems with his detoxification and he showed no symptoms of withdrawal. On 3 April, another prison doctor saw him and recorded that he thought the man was "an inveterate seeker of medication" and that his gabapentin had recently been stopped because he was misusing it.
28. On 5 April, the man saw another prison doctor who recorded that despite the man's description of his symptoms, it would not be appropriate to prescribe gabapentin or dihydrocodeine. He noted that the man had used Subutex illicitly and was on methadone, and this was further reason not to prescribe additional medication.
29. During the remainder of April, the man's mental health and detoxification continued to be monitored.

### **Holme House**

30. On 30 April, the man transferred to HMP Holme House. At his health screen it was recorded that he had alcohol detoxification at Durham, had a history of drug misuse and claimed to have used illicit drugs in the past month. It was noted that he was on a methadone maintenance programme. His medications were noted and it was also recorded that the man said that he had self-harmed several years previously after the death of a friend.
31. On 2 May, a nurse assessed the man's mental health when he said he felt anxious, agitated, and scared that somebody might attack him. He again referred to flashbacks and nightmares related to being assaulted nine years previously and that he heard the voice of his dead best friend telling him to join

him. He said he saw faces on the television but did not have other symptoms of psychosis. The man discussed three suicide attempts, once when he cut his wrists while in Durham prison five years previously, another time he took an overdose and said that his last suicide attempt was the year before, when he said he tried to hang himself but his brother-in-law cut him down. The man said he had no current thoughts of suicide or self-harm. He said his parents were a support and that he was hopeful things would improve in the future. He was concerned that people on the houseblock might recognise and attack him as he had previously been in prison for a sexual offence. This information was shared with prison officers and the following was recorded: "Spoken to in reference to concerns raised via the MHT (mental health team) and previous sexual offence, he states that he is not under threat and has had no person threatening him about his previous offences".

32. A nurse saw the man on 8 May, and he told her that he believed people on the houseblock were calling him a sex offender, but he was not being threatened. The man was unhappy when the nurse said she would need to pass on this information and said that if he had a gun he would pull the trigger. On further questioning, he said that while he wished he was not in prison he had no active suicidal thoughts or intention to harm himself. The nurse noted that he seemed paranoid and believed that other people were talking about him. He said he continued to hear the voice of his dead friend. He agreed to attend a mental health support group and to see a psychiatrist.
33. On 11 May, another prison doctor reviewed the man's medication. The man asked for gabapentin, mirtazapine (an anti-depressant) and dihydrocodeine, but the doctor decided it was not appropriate to recommence this medication at that time.
34. On 17 May, the man attended a mental health support group. An occupational therapist recorded that he was anxious and concerned about his mental health, but group activities distracted him from these preoccupations.
35. The man moved from Houseblock 1 to Houseblock 3 (the vulnerable prisoner unit) on 20 May, as he thought other prisoners knew he had previously been convicted of a sexual offence.
36. On 21 May, a nurse carried out another mental health review. The man told her he was experiencing nightmares and flashbacks from when he was attacked in the past. He told her that although he spent much of his time in his cell he came out during association periods (when prisoners are able to spend time with each other) and he got on with his cellmate. He said that he spent time writing letters and was looking forward to a visit from his family. The man asked to be referred to the drug and alcohol recovery team (DART) before he was released. The man reported feeling low in mood and that he felt "paranoid" although he did not expand on this. The nurse observed that the man maintained good eye contact, his speech was appropriate in terms of rate, tone and content and there was no evidence that he was neglecting himself. The nurse noted that she would add the man to the psychiatrist's list for further assessment.

37. On 30 May, a nurse who facilitated the mental health support group and recorded that the man had engaged in acupuncture but was restless. He had to be asked to sit still a number of times. Once the acupuncture took effect he relaxed.
38. On 5 June, the man's personal officer (each prisoner is allocated a personal officer to support them and act as a first point of contact) made the following entry in his record:

"I have recently become the man's personal officer and I'm currently on night shift duties. He appears to be unemployed and I will speak to him on my return, to ascertain if he had any experience/preference regarding work. No issues raised".

This was the last entry by an officer in the man's P-NOMIS computer record.

39. On 7 June, a psychiatrist saw the man and considered that he appeared to have quite a severe impairment of his short term memory, which he thought more likely due to alcohol abuse rather than a head injury. The psychiatrist noted that the voices he described were consistent with alcoholic hallucinosis, but they could also be related to epilepsy. The psychiatrist decided that the man should have a trial of anti-psychotic medication but first the basis of his diagnosis of epilepsy needed to be checked. He noted that he might also need anti-depressant medication. It was not clear whether the anti-psychotic medication could be administered safely in prison or whether he would require transfer to a psychiatric hospital. This issue does not appear to have been subsequently revisited.
40. On 8 June, a mental health nurse faxed a letter to the man's community surgery explaining that the prison mental health team needed to view the man's medical history in relation to a claimed head injury and epilepsy so that the most appropriate medication could be given. A nine page response was faxed back from the surgery later that day with a patient summary for the man. The fax was addressed to the "Prison Mental Health Team" but it does not appear that the mental health team ever received it or reviewed the information. Nevertheless, one of the prison doctors saw the community GP records that day and recorded that the man had been prescribed mirtazapine, gabapentin, DHC (dihydrocodeine), and zopoclon, which he considered were unsafe combinations. He noted that the man was likely to be addicted to his prescribed medication and had a history of dangerous use of illicit substances. The prison doctor noted the medical record 'best not to prescribe.'
41. On 13 June, a nurse facilitated the mental health support group which the man attended. She recorded that he had acupuncture, played cards and took part in the group's discussions. He did not highlight any issues about his mental health.
42. On 14 June, the mental health nurse recorded that she had reviewed the man who was very down and close to tears. He said he was finding it difficult to

cope in prison and he often wished he was dead, but he had no plans or intent to harm himself, and had good protective factors in his family. The man said he was struggling mainly due to “people talking about me” and had had pains since his medications had been stopped. The nurse considered it was likely that he was hallucinating. She noted that the nature of his epilepsy/blackouts needed to be established before the recommended anti-psychotic medication could be prescribed. She noted from the record that the prison doctor had recently seen the man’s community GP records and that she would see if they were available for psychiatrist to review.

43. On 21 June, a member DART staff saw the man and recorded that he had completed his assessment, recovery plan and self-harm minimisation and she would check whether it was appropriate to include his parents in his recovery interventions and updates. The same day, a mental health nurse recorded that the mental health team had still not received the man’s community GP records and ‘admin’ would chase them up.
44. On 25 June, the mental health nurse reviewed the man. The medical records stated that he could not provide any additional information about his GP. He said that he did not have epilepsy but he had been on phenytoin (an anti-epileptic drug) for blackouts a numbers of years previously. The man said that he believed people were still talking about him, calling him a sex offender and tapping on the pipes. He did not think this was the result of a mental illness.
45. At 9.02am on 26 June, a further fax was received from the man’s previous community GP with his patient summary. The fax was addressed to an administrative member of staff. His medical record was noted to say that it had been placed in the mental health tray for their attention. Again it does not appear that this was ever acted upon by any member of the mental health team.
46. The same day the man attended the mental health support group. It was recorded by the nurse that he “presented as settled and engaged well with staff and peers, although quiet at times.” The man highlighted no issues during the session.
47. Two days later, on 28 June, a nurse saw the man’s at his request. She recorded that he wanted to discuss with the nurse the possibility of transferring to another prison. He asked when he would be seeing the psychiatrist and the nurse explained that this would be the next week. The man stated that he believed that staff and other prisoners were talking about his previous offences, and that other prisoners were tapping messages on the pipes about this. He did not think this was a mental health issue. The nurse later spoke to the psychiatrist who asked that the man be seen by a prison doctor to discuss his queried epilepsy as he would like to start prescribing anti-psychotic medication.
48. On 29 June, the man’s cellmate moved out of the cell they shared and another prisoner moved in. The ex-cellmate explained to the investigator that he had moved because he wanted a larger cell and to share with someone who he worked with. The ex-cellmate said that when he first met the man he “wasn’t

too paranoid” but he “just seemed to get worse and worse”. The ex-cellmate said that the man had told him on the day he moved out, that he would harm himself. He informed staff of his concerns and he thought they had spoken to the man. Nothing was entered in the man’s record or in the houseblock observation book, where notable events and issues about prisoners are recorded.

49. On 4 July and 5 July the man did not attend a mental health appointment and the mental health support group. No reason was given. On 8 July, his new cellmate informed the man’s personal officer that he was concerned about the man’s mental health as he appeared to displaying signs of paranoia. When interviewed, the officer told the investigator that the man was usually a “steady prisoner”, but when she saw him during the afternoon of 8 July he was different. She said that the man had asked her to remove the listening device that was inside his cell light. The officer saw there was a small black fleck in the light shade, which appeared to be a dead insect. She suspected that the man thought that it was a listening device. The man told her he felt he was being monitored and watched all the time by cameras.
50. After she saw the man, the officer completed a mental health referral form as she did not think it was necessary for the man to see someone from the mental health team immediately. (The referral form was date stamped 10 July and recorded as being received by the MHT on 11 July). She recorded: “Is displaying bizarre behaviour. Feels everyone is talking about him. Is convinced his cell is bugged with listening devices. Shouting through his cell door on a night, telling others on the wing details of his convictions/offences”. The officer said she recorded her referral in the applications book for the houseblock. The applications book could not be found when the investigator visited the prison and copies of the entries from July 2012 have still not been provided.
51. The officer did not record in the houseblock observation book or in the man’s P-NOMIS case notes, any information about the man’s unusual behaviour or the referral.
52. The officer did not consider that the man needed to be monitored under suicide and self-harm prevention procedures. When interviewed she said that there was no indication in what the man was saying to suggest that he had any thoughts of self-harm. The officer also said that when she saw him the next day, 9 July, there was no further erratic behaviour. Although the officer was aware that the mental health team at Holme House were busy she was confident that the referral form would get through to them. She said:

“If he was continuing in the same vein I would have made a phone call but I was happy that the form would take its course and by the Monday (9 July) there were no other issues”.
53. On the same day, the man did not attend his appointment with the psychiatrist and no reason was given. In a letter he wrote to his sister, dated 9 July, the

man gave no indication that he intended to harm himself and he appeared to be looking forward to his parents' next visit.

54. On 10 July, the man attended the mental health support group. The member of staff who managed the group meeting recorded the following:

“Presented as unsettled on occasions and talked with fellow patients about perceived bullying and intimidation from other prisoners on HB [houseblock], discipline staff aware of the same. Received acupuncture during session but clearly found it difficult to settle. Requesting to speak to KW [key worker] RMN [Registered Mental Health Nurse] made aware of request. No other concerns of note.”

### **11 July 2012**

55. At around 7.55am on 11 July, staff unlocked the man's shared cell (Houseblock 3 C1-11) so he could collect his breakfast. The man and his cellmate returned to the cell two minutes later with their breakfast. They were then locked back in their cell. Just under an hour later, at around 8.50am, staff unlocked their cell again to enable the man's cellmate to attend a visit with his solicitor. The man was sitting on the bottom bunk bed when he unlocked the cell. They did not speak but as the cellmate left the cell the man pushed the door closed and it locked shut.
56. At around 11.08am, staff unlocked the man's cell for him to collect his medication. The man was at the end of the cell, half slumped against his bed, with his legs outstretched and his head tilted backwards. His throat had a very large cut across it and the officer noticed that he did not appear to be breathing and there was no blood flowing from the wounds. The man's chest was stained with blood and there was a lot of blood in the cell. The officer asked for assistance and for a code red response (a radio code which is used to indicate an emergency). A Senior Officer (SO) informed the control room. Another officer came to the man's cell but when he realised there nothing he could do to assist he left to direct healthcare staff to the area. When the healthcare staff arrived the first officer on scene left the area and went to the staff office.
57. Healthcare staff arrived at the cell at around 11.09am. In her statement one of the nurses said that she immediately checked his right carotid artery (in the neck) for a pulse but could not find one. She checked the man's pupils with a pen torch and they were fixed and dilated. The nurse also found evidence of rigor mortis<sup>2</sup> as the man was white, cold and difficult to move. At 11.10am, she was joined by other healthcare staff. They placed the man on the floor and requested a doctor.
58. In his statement, an officer said it was very difficult to move around the cell because of the amount of blood. He moved the clothing locker out of the cell to make more room; a nurse passed him a piece of plastic cutlery with a razor

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<sup>2</sup> Rigor mortis is a condition of extreme stiffness affecting the arms and legs after death making it virtually impossible to bend the wrists, elbows or knees.

melted into it which he placed in the sink. When additional healthcare staff arrived the officer left the cell.

59. The Orderly Officer went immediately to the man's cell on Houseblock 3 when he heard the emergency call. When he arrived he recorded that there "was already numerous HCC (healthcare) staff in attendance". He contacted the control room to request an ambulance which was called at 11.10am and that the duty governor and police should be asked to attend. At 11.18am, a prison doctor confirmed that the man was dead. Paramedics arrived at 11.22am and the doctor explained they were no longer required.
60. The prison activated its death in custody contingency plan. As usual with a death in custody, the police visited Holme House and interviewed staff. They found no suspicious circumstances and later confirmed that no-one else was involved in his death.

### **Contacting the man's family**

61. During the afternoon of 11 July, an operational manager and Principal Officer visited the man's family to inform them of his death. Another officer was appointed as the prison's family liaison officer (FLO) and maintained contact with his family. In line with national guidance, Holme House offered financial assistance with the costs of the man's funeral, which took place 23 July 2012.

### **Support for staff and prisoners**

62. Prisoners on the houseblock were informed of the man's death during the morning of 11 July and asked whether they required any additional support. All the prisoners in Holme House who were subject to self-harm and suicide monitoring were reviewed in case they had been affected by the man's death.
63. Prison managers held a meeting for staff immediately involved to share information and provide reassurance and support. The staff were shocked that the man had apparently taken his own life as they never considered it was something he would do.

### **Post-mortem**

64. The preliminary post-mortem examination recorded the man's death as being due to incised wounds to the neck. The pathologist recorded extensive incised wounds to the neck with "hesitation" marks, damage to windpipe (trachea) and muscle, blood in airways. There were no grip marks and no evidence of third party involvement.

## ISSUES

### Medical care

65. A review of the man's clinical care was carried out by doctor. We do not repeat all his recommendations in this report, but draw the Head of Healthcare's attention to them.
66. In his review, the clinical reviewer notes that the healthcare records demonstrate that the mental health team at Holme House were routinely in contact with the man and reviewed his care. We are also satisfied that the man's detoxification from alcohol and drugs was appropriately managed.
67. The clinical reviewer says that the man's prison medical records were generally of a good standard, appearing to be mostly contemporaneous or made soon after the event. Entries were dated, timed and assignable to an individual whose role was also recorded. However from subsequent interviews it appears that access to SystmOne (the medical computer system) can be a problem for some mental health staff due to lack of access to appropriate terminals. This meant that some information recorded in the man's mental health record was not recorded on SystmOne. Information from the man's community GP about his past medical history was not scanned onto SystmOne to enable all medical staff, including the mental health team, easy access to his previous records.
68. SystmOne should be the primary record of care for a prisoner and should include all available medical information including any history, observations, interventions and medications to ensure a comprehensive record. It should be available to all healthcare staff regardless of whether they are in primary or secondary care.

**The Governor and Head of Healthcare should review the management of medical records to ensure that all clinical staff, including the mental health team, have appropriate access to the SystmOne record system and that this is used as the primary record of all care.**

69. The man was seen by a psychiatrist and a management plan was completed which advised that he should begin anti-psychotic medication subject to the need to clarify the basis for his diagnosis of epilepsy. This assessment took place on 7 June 2012, but at the time of his death on 11 July, just under five weeks later the medication had still not been started as his community GP records had not been reviewed as required. This information had been received the same day it was requested on 8 June. There is no evidence that mental health staff saw or considered it. It appears to have gone missing, although a prison GP used the community records on 8 June. A second set of his records was obtained on 26 June and put in a tray for the mental health team; however these had still not been accessed by any member of the mental health team before his death. This was a significant failing.
70. From interviews with staff, it appears that medical information coming into the prison can be handled in different ways depending on whether it addressed to

primary care or mental health. There is no way of tracking information such as letters or faxed reports once they have arrived.

**The Governor and Head of Healthcare should review the management of incoming medical information to ensure a consistent and auditable process is in place that makes best use of SystemOne, and that all relevant staff are aware of where to access such information.**

71. Once the psychiatrist had advised anti-psychotic medication, subject to a check of his epilepsy diagnosis, there was a lack of clarity over who should follow this up. An appointment was made with the prison doctor, but the clinical reviewer is not satisfied that the GP would have been the most appropriate person to make this assessment, or that the GP would have been clear about the basis for the assessment. In the clinical reviewer's opinion, a stronger lead could have been taken by the psychiatrist as it was he who had recommended treatment. As no assessment was made it is not possible to say whether the medication would have been appropriate. Nor is it possible to say whether, had the man commenced this medication, there would have been any effect on the final outcome as anti-psychotic medication needs time to take effect.

**The Head of Healthcare should ensure that when a decision to commence medication has been taken by a prescriber, there is a process to ensure that this is done in a timely manner. The original prescriber should be informed if there is any delay and a clear management plan agreed and recorded.**

72. From the available evidence it is clear that the man's mental health condition was pre-existing before his arrival in custody. Unfortunately the mental health team's access to his previous medical records was hindered by the poor management of incoming clinical information at Holme House. This added to the difficulties of carrying out a comprehensive and meaningful psychiatric assessment.
73. In his review, The clinical reviewer says:

"The process for the review of the man's mental health was generally equitable to that care expected in the community, apart from the delay in commencement of treatment advised by the consultant psychiatrist in the weeks prior to his death. In this respect, the provision of care by the mental health provider falls below the standard of care that would be expected of a provider in the community in my opinion, as the delay would not be within the parameters of what is deemed reasonable had the man been seen in the community."

### **The emergency response**

74. The man was discovered at around 11.08am. Within a few minutes the officer involved had radioed for and received assistance and an ambulance had been called. As it was evident that the man had been dead for some time staff did

not attempt resuscitation. A prison doctor pronounced death at 11.18am. Paramedics arrived 14 minutes after being called.

75. From both the records and interviews with staff it appears that, after the man was discovered, all of those involved acted quickly and in a professional and considerate manner. In his review, the clinical reviewer concludes:

“The final event of the man’s life is obviously very traumatic for all involved. From the records and interviews with staff it appears that the man was dead when discovered. The staff understandably initially struggled to know how to deal with the horrific scenario with which they were presented. They have however shown professionalism and sensitivity in their handling of the situation. A considered decision was taken not to immediately embark on cardio-pulmonary resuscitation<sup>3</sup>; I consider this to have been an appropriate decision in the circumstance. Management of the scene and preservation of evidence appears to have been done with great efficiency.”

### **Awareness of risk factors**

76. We have considered whether staff should have opened an ACCT plan for the man, particularly as we have been critical in the past when prison staff place too much reliance on what the prisoner tells them and ignore the weight of other risk related information. When the man was first recalled to prison, HMP Durham were informed that the court staff were concerned he was at risk of suicide and self-harm. This was considered but discounted. He also had a history of drug and alcohol misuse, as well as mental health problems. All of these factors are significant indicators of risk of self-harm and suicide. Set against these, the man consistently said he had no thoughts of self-harm or suicide when asked directly. His behaviour and demeanour gave no indications otherwise.
77. The man was assessed by a number of different people after his return to prison, none of whom concluded that he needed to be subject to ACCT monitoring. This included mental health professionals, and he was seen by a psychiatrist on 7 June, who did not indicate that he considered the man was at risk of suicide. However, we are concerned that there is no record that those assessing his risk of suicide or self-harm fully considered all his known risk factors, such as being recalled to prison, previous suicide attempts, the warning from court about his risk, substance misuse and mental health problems. While it is possible that these factors were considered, this was not documented and most assessments referred principally to the man’s personal presentation.
78. Staff judgement is fundamental to the ACCT system. At its core, the system relies on staff using their experience and skills, as well as local and national assessment tools, to determine risk. It is not an exact science. However, we are concerned that there is little record that the range of known risk factors

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<sup>3</sup> Cardiopulmonary resuscitation (often described as mouth-to-mouth resuscitation) is a combination of rescue breaths and chest compressions to keep blood and oxygen circulating in the body.

were fully taken into account and balanced against the man's personal presentation.

**The Governor and Head of Healthcare should ensure that all the known risk factors are fully considered and documented when determining a prisoner's risk of self-harm or suicide.**

79. When an officer saw the man on 8 July, although she was concerned about his behaviour, she decided not to open an ACCT. She referred the man to the mental health team, but was satisfied that it did not need to be an urgent referral. The officer did not record what had happened in the houseblock observation book or in the man's individual prison record. This meant that other staff on the houseblock were not alerted to the man's behaviour.
80. The houseblock observation book and individual prisoner records are important methods for effectively passing key information about a prisoner's wellbeing and behaviour from shift to shift and it is important that these are used effectively to alert staff to any concerns.

**The Governor should ensure that all officers effectively use the houseblock observation books and individual prisoner records to alert other staff when there are identified concerns about a prisoner.**

## RECOMMENDATIONS

At the draft report stage, the National Offender Management Service (NOMS) responded to the recommendations. That response is included in italics below the recommendation.

1. The Governor and Head of Healthcare should review the management of medical records to ensure that all clinical staff, including the mental health team, have appropriate access to the SystmOne record system and that this is used as the primary record of all care.

*Accepted - SystmOne is the primary record used by all Healthcare and Mental Health staff. Mental Health team have access to SystmOne within the healthcare department. Mental Health team access to SystmOne will be improved when SystmOne is installed into the Oaks unit (Mental Health team office).*

2. The Governor and Head of Healthcare should review the management of incoming medical information to ensure a consistent and auditable process is in place that makes best use of SystmOne, and that all relevant staff are aware of where to access such information.

*Accepted - Healthcare and mental health staff are to be sent reminder of the importance of checking SystmOne and where to access SystmOne. New system is now in place to ensure prompt retrieval of medical information between healthcare and mental health team.*

3. The Head of Healthcare should ensure that when a decision to commence medication has been taken by a prescriber, there is a process to ensure that this is done in a timely manner. The original prescriber should be informed if there is any delay and a clear management plan agreed and recorded.

*Accepted - Review of prescribing practices are being undertaken by GP medical lead on behalf of Care UK, North East Offender Health and Offender Health Medical Director of Tees, Esk, Wear Valley Trust.*

4. The Governor and Head of Healthcare should ensure that all the known risk factors are fully considered and documented when determining a prisoner's risk of self-harm or suicide.

*Accepted - A system of annual reminders of staff responsibility with regard to the management of self-harm warnings has been put in place. A Governor's order has been circulated describing areas of risk to consider, this will be issued yearly to all staff, including those working in healthcare and mental health. All relevant departments (Safer Custody; Healthcare; Mental health; Reception; Video Link; Custody Office; Offender Management Unit; Residential; First Night Centre and Induction) have been made aware that all newly arrived prisoners are at a heightened risk of suicide/self-harm. A member of the Safer Custody Department will see all licence recalls the day following reception or the next working day or, in the case of being informed*

*by the Custody Office, the next day or next working day following being informed.*

5. The Governor should ensure that all officers effectively use the house block observation books and individual prisoner records to alert other staff when there are identified concerns about a prisoner.

*Accepted - Daily Management checks are conducted of observation books by Duty Governors. CNOMIS case notes are checked regularly by wing managers to ensure they are being used appropriately.*