Investigation into the circumstances surrounding the death of a man at HMP Holme House in January 2007

Report by the Prisons and Probation Ombudsman for England and Wales

July 2008

This is the report of an investigation into the death of a man at HMP Holme House on Sunday 21 January 2007. The man was discovered kneeling on the floor of his cell in the segregation unit with a ligature around his neck attached to a metal picture board hook on the wall. Despite efforts to resuscitate him, the man did not regain consciousness and was pronounced dead in his cell. He was 50 years old and had been in prison custody for just one day.

I offer my sincere condolences to the man's family and to all those touched by his passing.

One of my Family Liaison Officers contacted the man's family to learn of the particular concerns they had about his death. I hope that this report answers all their questions.

The investigation was undertaken on my behalf by two of my investigators. North Tees Primary Care Trust undertook a clinical review of the care the man received. I must apologise for the delay in producing this report.

Self-evidently, it cannot be known what was in the man's mind when he attached a ligature around his neck. However, I note that he had been located at Holme House because his nearest prison was overcrowded. He was detoxifying from heroin and other drugs. He had been prescribed but not received medication, and the medication he had received in police custody (dihydrocodeine – a drug not licensed for opiate withdrawal) had been interrupted. Finally, he was located in the segregation unit following a fight with his cell mate. In retrospect, these were all risk factors. However, I must also acknowledge that, despite requesting medication for a stomach complaint and appearing irritated when he did not receive it, the man had not given staff special cause for concern about his welfare.

I make four recommendations.

Stephen Shaw
Prisons and Probation Ombudsman **July 2008**

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SUMMARY

On 18 January 2007, the man who is the subject of this report was arrested. The man was a heroin user and had taken some the day before he was detained. Whilst the man was in police custody, he was prescribed dihydrocodeine (an opiate substitute) to help manage his drug withdrawal symptoms. After appearing at court on 20 January, the man was remanded in custody. Due to overcrowding, he was unable to be accommodated at his nearest prison and was taken to HMP Holme House in Stockton-on-Tees.

On arrival at Holme House, the man was interviewed by a nurse as part of the normal reception procedure. He said there was a family history of suicide, but this was not pursued further by the nurse who did not consider relevant at the time.

The man was not given any medication but was observed overnight in the prison's healthcare centre. The next morning (21 January), he was prescribed dihydrocodeine as part of a detoxification programme. With his agreement, the man moved to the Drug Dependency Unit in the afternoon. He was placed in a cell with another prisoner, but less than fifteen minutes later an officer found them fighting. They were separated and the man was taken to the segregation unit after saying that he would smash up his cell if he was left on the Drug Dependency Unit.

At 8.00pm, the man rang his cell bell and told the officer who answered that he was having stomach and chest pains. He was seen by a nurse approximately an hour later. His blood pressure and heart rate were checked. The man asked the nurse for some of the medication that had been prescribed earlier, but she said that she could not give him medication as she did not have it. The man was not happy with this reply.

At about 10.30pm, the officer on duty in the segregation unit noticed that the man's cell light was the only one still on. He looked through the observation panel and saw the man kneeling on the floor with a length of fabric around his neck attached to a notice board bracket. The officer spoke to the man through the cell door but there was no response.

Staff entered the man's cell and administered CPR, but were unable to resuscitate him. My report explores the issue of locating prisoners undergoing detoxification in the segregation unit. It also includes recommendations concerning the continuity of care and medication.

THE INVESTIGATION PROCESS

1. My investigator visited Holme House three days after the man's death. She met the Governor and after visiting the segregation unit discussed whether the cells there could be made safer. My investigators visited Holme House on two further occasions. They were given access to the man's prison records including his medical record, statements from staff and other documentation.

2. Notices to staff and prisoners announcing the investigation were displayed around the prison. One of my investigators met representatives from the Independent Monitoring Board and the local branch of the Prison Officers' Association to offer them the opportunity to raise relevant issues.

3. My investigators contacted Cleveland Police who said that there were no suspicious circumstances and no third party involvement in the man's death.

4. The man's family was offered, and accepted, the opportunity to contribute towards the investigation process. One of my Family Liaison Officers made contact with the man's family. They spoke positively of the kindness they had been shown by Holme House, but had several questions about the circumstances surrounding the man's death. They understood that before his death the man had a physical altercation with someone at the prison and had hit an officer, but when Holme House's Family Liaison Officer had visited they were told it was a verbal altercation. They sought clarification whether the man had a physical altercation before his death, whether he had left a letter to explain his actions and how his drug use and medical needs had been met.

5. The family asked for clarification of the heroin substitute the man had been given and whether he had received it on the day he died. They were concerned why access to the pharmacy appeared to be limited, with the man being told he would have to wait until the next day for his medication. They wondered whether he had blacked out because of the pain of going 'cold turkey' and had choked to death.

6. When they viewed the man's body before burial, the family noticed what appeared to be a cut on his left index finger and a bruise on the right side of his lip. They questioned how he might have got these.

7. The man's family felt strongly that he was not the sort of person to take his own life and had not been known to suffer from depression. Two close relatives had taken their lives but they were suffering severe depression. In contrast, the man was known to be self-centred and tended to only focus on himself and satisfying his own needs.

8. The man had a fear of enclosed spaces, especially when he was alone. His aunt said that he would rather sleep outside than in a small flat or bed-sit. She had asked prison staff about this, especially in the light of the man being in the segregation unit, but they were not aware he had suffered from this fear. My investigator also found no evidence to suggest that the man had ever raised this as a concern with staff

9. A draft version of this report was given to the man's family and to the Prison Service to check for factual accuracy. I have considered their comments and have made some amendments to my report in the light of their observations.

10. A clinical review was requested from North Tees NHS Primary Care Trust. I am grateful to the Head of Risk Management, and the Head of Healthcare Governance, at North Tees PCT.

11. HM Coroner for Teesside was informed of the nature and scope of my investigation. My report will be sent to the Coroner to assist his further enquiries.

HMP HOLME HOUSE

12. HMP Holme House in Stockton-on-Tees is a local prison which means that it normally receives males who have been remanded in custody or sentenced to imprisonment by the Magistrates' Courts and Crown Courts of Teesside and North Yorkshire. However, Holme House has regularly accommodated prisoners at short notice from other overcrowded prisons.

13. Holme House is a modern prison that was opened in 1992. It holds up to 994 prisoners mostly in cells holding two prisoners.

14. Her Majesty's Chief Inspector of Prisons, Ms Anne Owers, inspected Holme House in April 2005. Her inspection report described a prison, "subject to sudden overcrowding drafts and the arrival of short-term and remanded prisoners requiring support and detoxification." Her report continued, "This inspection recorded some extremely good work in detoxification and healthcare, where uniformed and specialist staff were working together to produce excellent outcomes. Suicide and self-harm prevention was well managed: and more prisoners told us that they felt safe in Holme House than in comparable establishments. They also reported better than average relationships with staff."

15. Since I took over responsibility in 2004 for investigating all deaths in prisons, there have been eight apparently self inflicted deaths at Holme House. The recommendations I have made as a result of my investigations have revealed a variety of issues, none of which has particular relevance to the circumstances of the man's death.

16. Healthcare at Holme House is provided by North Tees Primary Care Trust. The prison has a healthcare centre that is staffed by nursing staff during the day. Between 9.00pm and 7.00am, an Operational Support Grade is based there as a night patrol. One nurse provides night cover for the whole prison at night. A doctor can be contacted out-of-hours through a local General Practitioner surgery.

17. The prison pharmacy is closed on Sundays. New prescriptions issued over a weekend cannot be fulfilled until the pharmacy re-opens on a Monday. The healthcare centre has an emergency cabinet for medication such as insulin which might have to be administered in an emergency. Otherwise, nurses can only issue over-the-counter type medicines such as paracetamol.

KEY EVENTS

18. The man did not have a permanent home. He visited relatives and friends in his home area seeking food and shelter. On 18 January 2007, he was arrested. The victims of his alleged offences were two relatives and a friend.

19. Whilst in police custody, the man told the Forensic Medical Examiner that he was a heroin user and had last taken some the day before his arrest. His medical record sheet indicates that he was anxious about withdrawal but had no plans to harm himself. He was prescribed dihydrocodeine, an opiate substitute, and diazepam, a tranquiliser, whilst in police custody.

20. The man appeared at magistrates' court on Saturday 20 January. He was remanded in custody and scheduled to return to court on 23 January. Due to overcrowding, his local prison was unable to accommodate all the defendants who had been remanded in custody that day as it was full. As a result, five prisoners including the man were taken to Holme House.

21. On entering the prison, the man went through the reception process with an officer. In response to the standard questions of the Cell Sharing Risk Assessment (CSRA), the man told the officer that he was currently dependent on drugs, did not have concerns about sharing a cell and would not describe himself as a person who got angry/frustrated quickly. As part of his induction interview, the man admitted that his drug use was a problem and said that he wanted help and wanted to go the prison's Drug Detoxification Unit. The man was asked if he had any other worries, concerns or potential problems but replied "no".

22. At interview with my investigators, the reception officer recalled that the man had been disappointed about being in Stockton-on-Tees rather than his home town. Nevertheless, he had been complimentary about Holme House, making a joke and saying that it was cleaner than the last prison he was in. He had been pleasant and did not show any indications that he was at risk of self harm.

23. After being interviewed by the reception officer, the man was then seen by a registered mental health nurse as part of the normal reception procedure. The registered mental health nurse told my investigators that the man was "a bit cheesed off" with not being in a prison nearer to his home. He said he had been injecting himself with up to £50 worth of heroin a day. He appeared a bit anxious (which the registered mental health nurse assumed was due to having a fraught journey to Teesside), but was not showing the usual signs of drug withdrawal. Asked by my investigators whether it was uncommon for prisoners from outside the Holme House catchment area to be located there, the registered mental health nurse replied that it was not an uncommon experience as it depended on where spaces were available in the prison system.

24. The man was asked by the registered mental health nurse whether he had ever harmed himself, whether he felt like doing so and if he felt suicidal. The man answered "no" to each question. The registered mental health nurse completed a Secondary Health Screen assessment about the man. He asked the man: "Is there any history of illness running in your family?" The man replied that there was heart disease and suicides. Asked by my investigators whether he explored those answers further, the registered mental health nurse replied:

> "I thought the offer of suicides was maybe not relevant but I wrote it down because that was the answer he gave me … he said it was the male side members of his family but he didn't say how many and I didn't ask how many either … he was talking about members of his family and I don't know if there's actually any correlation between higher incidents of self-harm and self-harming family members. But it was planned for him to go to the hospital [healthcare centre] that night anyway."

25. The registered mental health nurse told my investigators he explained the detoxification process to the man. He would be assessed for withdrawal symptoms, then further assessed by a medical officer before receiving detoxification treatment. The man's urine was tested for the presence of illegal drugs. He tested positive for benzodiazepine, opiates and cocaine.

26. The man was taken to the healthcare centre to be observed as an in-patient overnight. He was seen briefly by the team leader who asked him how he was. The man said he was fine. The healthcare team leader completed a Risk Assessment checklist on the man. She said that he was showing some signs of drug withdrawal such as sniffing, runny eyes and looking tired.

27. A nurse was on duty in the healthcare centre during the night of 20 January 2007. In interview, she recalled seeing the man during her rounds but had not had a conversation with him. He did not ring his cell bell or ask for medication.

28. On Sunday 21 January, a General Practitioner clinic was held between 9.00am and 11.00am. The GP saw the man as he was new to the prison. He asked her for the medication ranitidine to treat dyspepsia (indigestion) which he said he got from time to time. The GP wrote a prescription for 150mg of Ranitidine in the man's prescription chart under 'Not in possession prescriptions'. However, she did not make a written reference to the drug in his Continuous Clinical Record. The GP prescribed the man an eight day dihydrocodeine drug detoxification programme. In interview, the GP recalled asking the man specifically whether he had thoughts of self harm. She told my investigators that he dismissed the idea and shook his head.

29. After seeing the GP, the man was given 120mg of dihydrocodeine. On the Opiate Withdrawal Scale (which assigns numerical values to different

30. The man's administration record chart for opiate withdrawal was signed to say that 120mg of dihydrocodeine was given to him in the afternoon (the signature was not legible).

31. At about 2.30pm, the man left the healthcare centre and was relocated to the Drug Dependency Unit (DDU) on A wing of houseblock 4. The DDU accommodates prisoners previously identified with drug dependency who wish to tackle their problem by detoxification followed by education. It offers voluntary education courses designed to address issues around addiction and harm minimisation and to promote healthy living.

32. The man waited in a holding room on A wing until an officer escorted him to his cell, A2-09, about half an hour later. She introduced him to his cell mate who was already in the cell. The officer told my investigators that the man and his cell mate shook hands and the man offered him a light for his cigarette.

33. A second prison officer told my investigators that shortly before 3.15pm, the cell bell for A2-09 was pressed, illuminating the red light outside the cell. He opened the cell door and saw the man and his cell mate "arguing with each other quite aggressively … shouting and swearing, threats." The officer said that the man's cell mate was the main aggressor. The man was arguing back and standing his ground rather than being as aggressive. The second prison officer could not ascertain what they were arguing about. He said that the man's cell mate jumped down from his bunk bed and threw a couple of punches at the man who retaliated. The man's cell mate threw a few more punches, only one of which caught the man who turned his body away. The second prison officer shouted at them to stop but did not physically intervene as he was by himself. He shouted for staff assistance and another member of staff pressed the general alarm at 3.15pm.

34. The second prison officer guided the man out of the cell as he was near the door, then shut it. He did not notice that any injuries had been caused and neither prisoner said that they had sustained any. The second prison officer did not consider the blows to have been forceful.

35. Staff arrived on A wing in response to the alarm being raised and the man was placed in a holding room on the wing. A principal officer (PO) was in charge of managing the incident. He told my investigators that he asked the man what had happened. The man replied that he had been involved in a fight with his cell mate as they were not getting on. The principal officer said that the man's manner was aggressive and that he said, "If you

36. Cleveland Police interviewed the man's cell mate on 22 January. An entry in the wing observation book described him as "a strange, bizarre and unpredictable prisoner". The cell mate said the man did not speak much but said where he was from and that he had been in prison before. According to the man's cell mate, the man washed his face and brushed his teeth. The man's cell mate told him to use some deodorant as he smelt very sweaty, but the man just got into the bottom bunk bed without doing so. When an officer opened the cell door, both of them got off their bunk beds. The man's cell mate said that the man kicked him above the left knee, so he had hit the man twice with his left hand and once with his fist to the side of his face and the back of his head. The man's cell mate said the man had not given any indication that he had thoughts of taking his own life at this time.

37. The man was escorted to the segregation unit by the reception officer (who had dealt with him on reception the day before). He walked there without behaving aggressively or being handcuffed. The man told the reception officer that his cell mate had tried to take his tobacco from him.

38. When the man arrived at the segregation unit, he was strip searched and then placed in cell 18. The segregation unit holds up to 26 prisoners in single cells. On Sunday 21 January, there were 11 prisoners including the man. Five others were serving periods of punishment, two were there for reasons of good order or discipline, and three prisoners were cleaners who lived in the unit. The man was the only one awaiting a hearing before a governor (an adjudication).

39. An Initial Segregation Safety Algorithm was completed by a nurse at 3.30pm. (A safety algorithm is a flow chart that shows whether it is appropriate to keep a prisoner in conditions of segregation and whether there are any healthcare reasons against doing so. The flow chart consists of five set questions to be answered "yes" or "no".) In response to the algorithm, the nurse ticked "no" to the man needing an NHS secure bed. In addition, he had not self harmed, was not taking anti-psychotic medication, and did not show signs of being acutely unwell through withdrawal of drugs injury or psychosis. She ticked "no" to the question whether the man would be unable to cope with segregation. The Initial Segregation Safety Assessment asks, "Are there any apparent clinical reasons to advise against segregation at this time?" but the nurse signed the form without answering the question. The duty governor countersigned the safety algorithm at 4.10pm.

40. A segregation officer told my investigators that the man was concerned about his belongings that had been left on A wing. He was told they would be packed up by houseblock 4 staff and brought to him at a later time. The segregation officer said that the man did not show any outward signs of feeling under stress and, apart from his belongings, did not ask for anything else.

41. The rest of the afternoon passed without incident. An officer arrived for night duty at about 7.15pm. He was working the shift just for one night as a favour for a colleague. After a staff handover where he learnt that the man had been brought to the unit earlier, he checked that all the prisoners in the unit were present and well. The night officer was the only member of staff on duty in the unit. He told my investigators that, when he checked the man, he was in bed and appeared to be asleep. He did not respond verbally to the night officer talking to him but the night officer saw him move in bed. The night officer returned to the man's cell at 7.40pm to give him a copy of the notification that he would be subject to a disciplinary hearing concerning his fight with his cell mate. The man commented that he did not have his glasses to read the documentation.

42. At 8.00pm, the man pressed his cell bell. When the night officer answered it, the man asked to see a nurse because he was having stomach pains and felt as if he had pains in his chest. The night officer told my investigators that the man was sitting in bed but did not look distressed. He telephoned the nurse (the only nurse on duty), and she said she would come as soon as she was able as she was attending to something else. The man rang his cell bell again at about 8.20pm and was told that the nurse would see him as soon as possible.

43. About half an hour later, the nurse arrived at the segregation unit, accompanied by three officers. The man's cell was unlocked by an officer and the nurse entered the cell whilst the officers waited at the door. She asked the man what was the matter. He replied that he had stomach pains. The nurse asked whether it related to him being restrained earlier but he said no, he had an ulcer. According to a senior officer (SO) (one of the staff accompanying the nurse), the man's blood pressure and heart rate were checked. The nurse told the man that she could not give him any medication as it should have been issued during the day. She would arrange for the man to see the doctor the next day. In interview, she described the man as not showing obvious signs of being in pain – his speech was normal and he made good eye contact. The nurse told my investigators that the man chatted to her, but he was slightly disgruntled because he was not going to get medication. He told her the doctor he had seen earlier had prescribed medication and he wanted it. He got up and, although the nurse momentarily thought that he might become abusive, sat on a seat near his window. The nurse said that she told the man that if he felt worse he could ask to see her again. She then left his cell. When the nurse got back to the healthcare centre, she read the man's medical record to see whether he had been prescribed medication. She telephoned the night officer to say that the man was not prescribed

44. At about 9.30pm, the night officer told the man what the nurse had said. The man just shook his head whilst drinking a cup of tea. The night officer had been activating various pegging points around the unit. (This is a means of ensuring that a member of staff is properly monitoring the unit.) He told my investigators that he left the office at 10.30pm to peg. When he had finished, he noticed the man's cell light was the only one still on. The night officer looked into the cell through the door hatch and saw what appeared to be a strip of torn blanket attached to a picture hook possibly tied around the man's neck. He found it difficult to see whether it was actually around the man's neck. The man was at the bottom of his bed with his knees on the floor and his body crouched over the end of the bed frame. The night officer spoke to the man through the cell door but there was no response and the man did not move.

45. The night officer telephoned the Night Orderly Officer (the most senior officer on duty) for assistance. He told my investigators that he was carrying a radio but when he tried to use it, it "bleeped", indicating that the battery was low, so he used the telephone instead. The senior officer (the Night Orderly), two other officers and the nurse arrived within half a minute. Other staff were alerted to the crisis in the man's cell by an emergency radio message (a code blue) that was made at 10.37pm. An ambulance was called.

46. The senior officer unlocked the cell and the officers entered the man's cell. The night officer observed that the ligature was tied tightly around the man's neck with a knot and then looped to a bracket on the wall. The first officer lifted the man up whilst the second officer cut the ligature (a bed sheet) with a specialist tool and checked for a pulse.

47. The nurse arrived with an emergency medical bag. The second officer, a former nurse, took an airway and an ambu bag from the emergency bag to assist resuscitation. The first officer had started chest compressions. The man did not show any signs of life.

48. An ambulance arrived at 10.51pm. Paramedics went to the man's cell and attached a monitor to him to check whether it was possible that he was alive. The test was repeated twenty minutes later and confirmed that there were no signs of heart activity or breathing. The GP, who had seen the man earlier that day, arrived at Holme House at 11.40pm. She noted that his pupils were fixed and dilated and his corneas were cloudy. She pronounced him dead at 11.58pm.

49. A post mortem was conducted on 22 January 2007. It noted that there were several small abrasions on the man's head, neck and arms, as well

"The deceased had a small number of old injuries consistent with day to day activity and a moderate number of bruises and needle puncture marks consistent with pre-existing intravenous drug abuse ... The abrasions to the face and injuries to the left hand are essentially trivial. They did not contribute to death in any way … they are entirely consistent with the history of a scuffle ... In my opinion death was due to hanging (albeit in the form of incomplete suspension).

50. A clinical review of the care the man received in Holme House was undertaken by the Head of Risk Management, and the Head of Healthcare Governance, at North Tees Primary Care Trust. It is annexed to my report. The review found that there were some gaps in terms of record keeping, and that local guidelines should be drawn up to ensure consistency when taking a family history from a patient.

51. My leadl investigator asked the Head of Healthcare at Holme House, to clarify the position regarding the availability of medicines and the opening hours of the pharmacy. She said that the pharmacy was closed on Sundays and the healthcare centre had an emergency cabinet for medication such as insulin that might have to be administered in an emergency. Nurses could issue over-the-counter type medicines such as paracetamol, but any medication prescribed by a doctor at the weekend could not be issued until Monday when the pharmacy re-opened.

52. As part of her initial investigation, my investigator discussed the man's death with Cleveland Police. They queried the presence of an apparently obvious ligature point in the man's cell. At the end of her preliminary visit to Holme House, my investigator met with the Governor and expressed concern about the small notice board brackets in the cells of the segregation unit. The man had secured the strip of bed sheet he had used to tie around his neck to one of these brackets. On her return to Holme House in March 2007, my investigator found that the hooks were still present.

ISSUES

53. The man arrived at Holme House as one of several prisoners who would normally have been accommodated elsewhere. Because of severe overcrowding, he and the others had been sent to a prison a considerable distance from their home area. I understand it is not uncommon for Holme House to receive prisoners who came from outside its normal catchment area. (Given the population pressures upon the Prison Service, I also understand that the Service has very limited options.)

54. The man arrived in an unfamiliar prison, but appears to have been put at ease by his impression of how he was treated by reception staff and the appearance of Holme House. Whilst conducting this investigation, my investigators went to the reception area unannounced to observe how newly received prisoners were managed. Their perceptions concur with the feedback the reception officer says the man gave him.

55. Although the man was asked questions about his health by the reception nurse, his answers about a family history of heart disease and suicide were not followed up. In retrospect, this was a mistake. One of the purposes of a secondary health screen is to explore aspects of health in greater detail. I agree with the clinical review that guidelines to staff taking a family medical history need to be developed.

56. The man was correctly identified as a drug user. He was placed in the healthcare centre for observation, offered the opportunity for detoxification which he accepted, and after seeing a doctor the day after he arrived was started on a treatment regime. I am concerned, however, that the man was unable to receive symptomatic relief on the day he arrived at Holme House. He had been receiving dihydrocodeine when he was in police custody until 19 January and started his treatment in Holme House two days later. He was not given any treatment on 20 January because he had not been seen by a doctor.

57. The man's family has raised the issue of the pharmacy not being open on Sundays and lack of access to prescribed drugs. I share their concerns. From the nurse's account, it seems that the man was not aware that he would not be able to have ranitidine (a medication he had asked for by name) until the next working day and this irritated him. He told the nurse he had an ulcer although this had not been mentioned to the GP earlier. Nevertheless, he could not obtain relief for his stomach pains.

58. It would have been useful if the clinical review had addressed these areas as I do not have sufficient medical knowledge myself to assess whether dispensing practice accords with what a prison should be expected to provide. The Governor and PCT will wish to consider this further. They should also consider the use of dihydrocodeine which is not licensed for opiate withdrawal. I have no doubt that the use of methadone and subutex in place of dihydrocodeine has contributed to a reduced incidence of self-

I recommend the Governor and Primary Care Trust ensure that arrangements are made for prisoners who arrive at Holme House at the weekend and have been prescribed medication to be able to receive it.

I recommend that the Governor and Primary Care Trust review Holme House's policy on supporting prisoners undergoing detoxification to ensure continuity of care between police and prison custody. The PCT should further review the use of dihydrocodeine in respect of opiate withdrawal.

59. The man was placed in a cell with another prisoner in the Drug Dependency Unit. This arrangement broke down within minutes. I have read the man's cell mate's version of events as well as the man's explanation to the reception officer. I cannot say for certain what occurred, but there can be no criticism of the staff who decided that the man should be removed from the unit after threatening to smash up a cell if he remained there. A potentially disruptive situation should be defused before it escalates so it was reasonable to separate the man and his cell mate.

60. The man was withdrawing from drugs when he arrived at Holme House. Although on the day of his death he scored the minimum on the Opiate Withdrawal Scale, his urine sample taken the day before tested positive for benzodiazepines, opiates and cocaine. The man did not show signs of being acutely unwell, but the safety algorithm did not take account of the possible effects of segregation on someone undergoing detoxification. Segregation can heighten a prisoner's sense of isolation. I am very concerned by the significant number of deaths that have taken place in segregation units since 2004. (Although there was no indication that the man ever mentioned claustrophobia to staff, his family expressed concern to my Family Liaison Officer that the man had a fear of enclosed spaces.) It is not desirable that a prisoner who is undergoing detoxification should be held in the segregation unit unless this cannot be avoided. As a general rule, I would expect them to be moved back to normal location once they are no longer presenting challenging behaviour.

I recommend that the Governor reviews whether it is desirable to accommodate detoxifying prisoners in the segregation unit.

61. Although the man was concerned about the pains he was experiencing, and irritated that he would not be able to obtain any medication until the next day, his symptoms were not apparent to the staff as physical signs of drug withdrawal. Having seen the draft version of this report, the man's family were concerned that the nurse had underestimated the man's need for pain-relief. They believed that men were reluctant to show visible signs of distress and because the man was not "rolling around on the floor", he

62. With the benefit of hindsight, it appears that the man was more vulnerable than staff realised. I have not found evidence to suggest that staff at Holme House showed anything other than concern for the man. On the contrary, whilst in the Segregation Unit, the man was seen five times by the night officer between 7.30pm and 9.30pm.

63. The man attached the ligature around his neck to a small bracket that is normally used to hold up a cell notice board. Other cells in the segregation unit still retained them even after the man's death. In my draft report, I made a recommendation that Holme House remove the notice board brackets from segregation unit cells in an effort to make them safer. I acknowledge that it is almost impossible to eliminate all risks but measures to minimise them can be taken. I am pleased to learn that Holme House has taken action and removed the brackets so I have withdrawn the formal recommendation.

RECOMMENDATIONS

I recommend the Governor and Primary Care Trust ensure that arrangements are made for prisoners who arrive at Holme House at the weekend and have been prescribed medication to be able to receive it.

Accepted – The Prison Service responded "PCT to review the system of pharmacy cover at weekends to ensure all medication prescribed can be administered as soon as possible."

I recommend the Governor and Primary Care Trust review Holme House's policy on supporting prisoners undergoing detoxification to ensure continuity of care between police and prison custody. The PCT should further review the use of dihydrocodeine in respect of opiate withdrawal.

Accepted – The Prison Service responded "Full audit and review is to be undertaken of the detoxification programme to ensure best care is supplied. PCT to review their use of drugs in opiate withdrawal."

I recommend that the Governor reviews whether it is desirable to accommodate detoxifying prisoners in the segregation unit.

Accepted – The Prison Service responded "All prisoners are assessed on an individual basis regarding their suitability to be in the segregation unit by healthcare staff and authorised by a governor."

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