Investigation into the death of

a man

at HMP Durham in October 2004

Report by the Prisons and Probation Ombudsman
for England and Wales

March 2006

This is the report of an investigation into the circumstances surrounding the death on 21 October 2004 of a man at HMP Durham. The man was found hanged in his cell. He was 34 years old.

The investigation was conducted under the terms of the transitional arrangements agreed between my office and the Prison Service, which ran from 1 April 2004 to 30 November 2004. The bulk of the investigative work was conducted on my behalf by a senior manager (the senior investigator – SIO) at HMP Manchester. The SIO was assisted by a Principal Officer from HMP Wakefield. A clinical review was carried out by the Carestream Prison Lead from Northumberland NHS Trust. An investigator from my office liaised with the SIO during this investigation. I am grateful to all members of the team for their work.

One of my Family Liaison Officers accompanied by my investigator visited the man's mother. I know they offered their sympathy and condolences. I would like to take this opportunity to add my own condolences to the man's mother, to his other family members and to his friends.

I should also record here my thanks to the former Governor of Durham and his staff for the help the investigators received during the investigation. All staff co-operated fully and readily with the inquiry. I regret the delay in bringing this report to completion.

At the time of his death the man had only been in Durham for three days. He was a remand prisoner charged with murder having handed himself into police custody with a confession that he had murdered his girlfriend. The man had spent many years in prison custody and he told staff at Durham those years would stand him in good stead for whatever sentence would result from his latest offence. He denied any thoughts of self-harm or suicide and gave no indication to anyone of having any such thoughts.

I have made five recommendations. Two concern admission procedures in the case of prisoners charged with murder, one concerns documentation, one relates to contact with bereaved families, and one relates to staff training.

Stephen Shaw CBE **March 2006**
Prisons and Probation Ombudsman

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SUMMARY

On 17 October 2004, the man approached two police officers and told them that he had murdered his girlfriend. The man remained in police custody until 19 October when he was remanded by the court into custody at HMP Durham. The Prisoner Escort Record Form (PER) that accompanied him into Durham had been ticked by the escort staff to record concerns about him, such as drugs and alcohol issues, but it was not recorded that he was perceived to be at risk of self-harm or suicide.

On arrival in reception at Durham, the man's healthcare screening was undertaken by the Registered Mental Nurse (RMN) who had over 20 years experience in psychiatric medicine. The RMN said the man had been very co-operative, coming across as a person who was used to prisons and prison life. There was nothing about his mental health state to give cause for concern. The RMN was aware of the nature of the man's charges, so he contacted the Charge Nurse in healthcare to find out whether it was still the practice to admit to healthcare those charged with murder (this had once been the practice at Durham in accordance with previous healthcare standards). The Charge Nurse told the RMN that, provided he had no concerns about the man's mental health state, there was no need to admit to healthcare. The RMN offered the man the option to go to healthcare, but he declined saying that he had spent many years in prison and was quite happy to be located in a normal wing.

An officer saw the man in reception and gave him a smokers' pack. The man was offered a PIN Number, to enable him to use the telephone, but he declined the offer. After this, the man was located into a shared cell in C Wing, the identified first night induction unit.

Following his location, the man was seen by one of the prison's GPs. The man declined the medication available for drug detoxification, but accepted a continued prescription of dihydrocodeine for pain relief for a hand injury.

During 20 October, the man underwent stage 1 of Durham's induction process, seeing a range of staff including a principal officer (PO) for a reception board. A CARATs (drug advice service) worker tried to speak with the man but he declined the offer. The man saw a Community Psychiatric Nurse (CPN) in substance misuse as result of his referral for detoxification medication, but again refused the detoxification medication available. The man had wanted methadone, but as he was not on an existing prescription for that medication he was told that he could only have lofexidine (Britlofex) or symptomatic pain relief which he refused. The CPN in substance misuse observed the man to be in mild drug withdrawal, but displaying no major symptoms.

At about 1.45pm on the afternoon of 21 October, the man's cell-mate was taken to a social visit, leaving the man alone in their cell. All the cells on C3 landing were unlocked at around 2pm to allow for 'downtime' (out of cell) activities. After around 30 to 40 minutes, all the prisoners on C3 landing were locked back into their cells. The cell-mate was still on his social visit so the man was again locked alone in his cell.

At about 3.30pm, the first Officer unlocked the man's cell for him to go to the treatment room for his medication. The man was lying face down on the bottom bunk. A

ligature, made from a television power cord, was tied around his neck and attached to the underside of the top bunk. The first Officer summoned assistance and was joined by the second Officer. Other staff also responded to the alarm call and arrived quickly.

The first and second Officers supported the man's body and a Senior Officer untied the ligature from the underside of the top bunk. The man was placed on his back on the floor and the second Officer cut the ligature from around the man's neck. The Staff Nurse and another nurse commenced attempts at resuscitation and they were joined by two other nurses who brought an oxygen cylinder, a defibrillator and other first aid equipment. Examination of the man revealed that he had no vital signs, his pupils were fixed and dilated, and he had no palpable carotid or radial pulses.

Staff commenced cardio-pulmonary resuscitation (CPR) and continued until ambulance paramedics arrived at around 3.50pm, when they took over the attempts to resuscitate the man. Unfortunately, their efforts proved unsuccessful and the man was pronounced dead at 4pm by one of Durham's doctors.

When my staff visited the man's mother she said that she knew her son would take his life. She said that her son and his girlfriend shared a volatile relationship, but he had never hit her and once he had killed her he would not have been able to live with that fact. The man's mother said that she had thought about telephoning Durham to tell the staff about her fears.

The man did not leave a suicide letter so we can never be certain about his motives. However, whatever his reasons and at whatever point he made the decision to take his life, the man gave no indication either to staff or to his cell-mate that that he had any such thoughts. It could even be argued that he took particular care to present himself as a person with no undue worries about being back in prison and about facing what inevitably would have been a lengthy sentence.

The clinical review, has pointed out a number of risk factors in the man's case. These included his refusal of a PIN number, the fact that he was charged with murder, and the fact that he was going through detoxification. With these risk factors in mind, the clinical reviewer has suggested that admission to healthcare and/or the opening of an F2052SH would have been safer options.

SENIOR INVESTIGATING OFFICERS REPORT

INTRODUCTION

On the instructions of the Prisons and Probation Ombudsman, an investigation has been carried out into the tragic death of the man, a prisoner at HMP Durham.

The Senior Investigating Officer was a senior manager D HMP Manchester, assisted by a Principal Officer from HMP Wakefield.

The investigation team would like to offer their sincere condolences to the family and friends of the man for their tragic loss.

The investigating team would like to thank the Governor and staff of HMP Durham for their co-operation and assistance during the course of the investigation.

Particular thanks go to the invaluable assistance of the investigation liaison officers.

INVESTIGATION PROCESS

The investigation involved a period of 22 days between 22 November 2004 and 14 December 2004 conducting interviews and collating all documentation and then a further period completing the reports. This investigation was spread over a longer period than was envisaged, due in part to the resources issue mentioned above along with sickness and operational duty absences on the part of the SIO for which I offer my apologies.

Durham appointed two staff to act as liaison officers. Durham provided all the necessary documentation. All personnel co-operated fully.

Durham had made contact with the man's mother. The Deputy Governor also contacted the man's mother and offered her the opportunity to visit the prison to meet with staff and prisoners who knew her son. Staff from the Ombudsman's office visited the man's mother to offer her and her family the opportunity to contribute to the investigation if they so wished.

The Governor published a local notice to staff, and a separate notice to prisoners, announcing the investigation and offering them the opportunity of contributing to the investigation.

The Investigation Team met the Deputy Governor, and later, the local Prison Officers Association branch chairman, to inform them of the investigation. The chairman of the Independent Monitoring Board (IMB) was informed and offered the opportunity of contributing to the enquiry. A copy of the report from the IMB Member who attended the incident was submitted to the investigation team.

During the course of our initial inquiries we visited the cell in which the man died as well as visiting other areas of the prison with which the man had had contact. We reviewed all documentation and established a chronology of events.

All members of staff identified for interview were offered the opportunity of being accompanied by a work colleague or trade union official at interview. Terms of Reference were handed to all interviewees and all were given a transcript of their interview. A total of 20 people were interviewed, including the man's cell-mate who had since been transferred to HMP Acklington.

Given that the man was in Durham for only a very short period of time we invited as wide a range of staff and prisoners as possible who had contact with him to contribute.

A doctor from Northumberland NHS Care Trust carried out a clinical review into the man's care and treatment.

A comprehensive report was received from Northumbria Police covering the arrest, circumstances of the offence and a record of events concerning the man's time in police custody.

HMP DURHAM

HMP Durham is a large Victorian local prison. Durham holds all types and categories of male prisoners. The certified normal accommodation figure is 568, with an operational capacity of 785. Durham has operated close to its capacity for a number of years. On the day of Mr The man's death, Durham's prisoner population was 647. An average of 40 prisoners are discharged to, and received from, court each day.

Durham has seven adult wings (three of which were closed at the time of Mr The man's death). The prison has a gymnasium, a 20-bed health care unit and a small segregation unit. The prison provides educational classes, including basic skills, offending behaviour programmes, physical education and seven workshops.

The last Standards and Security Audit carried out at Durham in November 2002 included an examination of the suicide and self-harm procedures and rated them as 'acceptable'.

A full unannounced inspection by Her Majesty's Inspector of Prisons for England and Wales in August 2003 found that reception, suicide and self-harm and anti-bullying work were all carried out to a high standard. Durham was found to be providing a fundamentally safe and decent environment. It was noted that, in a pattern all too common in an overcrowded prison system, Durham was able to offer too little by way of purposeful activity, although it was found to be delivering what it could, consistently and humanely, reflecting the commitment and professionalism of staff at all levels – relationships between staff and prisoners were reported as being consistently good.

There had been five previous self-inflicted deaths at Durham in 12 months preceding the man's dearth – three were male prisoners and two were female (until recently Durham was a mixed prison). Action Plans arising from the investigations into these deaths were examined by the investigation team.

The investigation team's over-all impression is of a busy and purposeful atmosphere with little negativity and with good staff prisoner relationships.

THE MAN

The man was born in February 1970 and was the youngest of six children – three boys and three girls. His next-of-kin was his mother who lives in Hexham in Northumberland.

The man's record of offending was substantial and over the years his offending became more serious, influenced heavily by his drug misuse. He had five previous periods of custody as a juvenile and young offender between 1983 and 1993. He also had a number of custodial sentences as an adult offender between 1994 and 2002. The offences included burglary and theft, assault, escaping from lawful custody, offences of both actual and grievous bodily harm and wounding with intent.

The man was released from HMP Liverpool in 2002, having served a six year sentence for robbery and breach of a licence condition.

BACKGROUND

The man's mother said her son had been in and out of prison for 17 years and she considered him to have become institutionalised. She said that, whenever he went into prison or was transferred to a new prison, he would always telephone her to tell her of his new prison address and she would send him some money.

The man's mother said her son had used drugs for many years. His preferred method of withdrawal from substances was to do so without using prescribed detoxification medication or support.

The man's mother said that her son had been with his girlfriend for two years. It was a volatile relationship, although her son had never actually hit his girlfriend. The man's mother understood that her son's girlfriend had relationships with other men while in the relationship with her son and she would taunt him about this.

The man's mother said that her son had never previously harmed himself. However, once he had killed his girlfriend she thought he would not have been able to live with himself and so the man's mother knew he would take his life.

The man's mother told the staff from the Ombudsman's office when they visited that up to that point in time, 6 December 2004, she had received from HMP Durham neither a letter of condolence, nor any offer of help with funeral expenses. These matters were subsequently followed up with Durham and rectified.

EVENTS LEADING TO THE MAN'S DEATH:

17 to 19 OCTOBER 2004

On the early evening of 17 October 2004, the man approached a stationary police car and informed the two officers in the car that he had killed his girlfriend. He was taken into police custody while his story was checked. The man remained in police custody until midday on 19 October when he was remanded into custody at HMP Durham by the local magistrates' court, charged with murder. The Prisoner Escort Record (PER) form that accompanied the man to Durham recorded a number of risks, such as drugs and alcohol issues, but no perceived risk of suicide/self-harm.

A Senior Officer (SO) interviewed the man in reception at Durham. The Reception SO said that the man was fairly subdued and quiet. However, he was well versed in prison life and he gave the Reception SO no cause for concern.

The RMN saw the man for his health care assessment. The RMN is an experienced psychiatric nurse with many years' experience of working in prisons. The RMN said that the man had been very co-operative during the health screening process, giving the impression that he had been in prison a few times and was experienced in prison ways. The man gave no indication that he might have been contemplating self-harm. However, because he was charged with murder, The RMN contacted the Charge Nurse in healthcare to ask whether it was still the policy to admit into healthcare prisoners charged with that offence. The Charge Nurse advised the RMN that it was no longer the practice to routinely admit into health care those charged with murder, unless the prisoner requested admission or there were other indicators that he or she might be suicidal or mentally ill. Following this conversation, the RMN asked the man if he wished to be admitted to healthcare, but he declined saying that he had done 17 years in prison and was perfectly happy to be in a normal prison wing.

Part of the screening process is about use of drugs. The man said that he used drugs such as heroin, amphetamines and cocaine and he reported that he was 'rattling' (suffering the effects of drug withdrawal). As a consequence, the RMN ticked the relevant boxes on the health screening form for the man to be referred to the doctor and the drug detoxification team.

In the case of those charged with murder, a referral should have been made for the man to be referred to a CPN (community psychiatric nurse). The RMN said that he could not recall whether he made such a referral, however there was nothing about the man's mental health state to have warranted an urgent referral. The RMN made a note in the man's medical record that he had denied any thoughts of suicide or self-harm, but the RMN did not record that the man had declined an offer of admission to healthcare.

Another prisoner who was received into Durham at the same time as the man spoke with him while they were in reception. The man told this prisoner why he was in prison. The prisoner told the investigation team that he overheard reception staff asking the man whether he wanted to be placed in the healthcare unit, but again the man declined, saying he was alright. The prisoner was later located into the cell adjoining the man's cell.

The man was seen by an officer who explained to him the first night routines in the induction unit. The man accepted a smokers' pack and toiletries, but declined the offer of a PIN number (new prisoners are offered a PIN number to enable them to use the telephone). This officer said at interview that the man kept asking how long it would be before he would go to the wing from reception. Nothing had occurred to give this officer cause to feel concern about the man; it was not especially unusual for prisoners to decline a PIN number.

At around 3.40pm, the man was located into a shared cell in C wing (the first night induction unit). Following his arrival in C wing the man was seen by a prison GP for a drug detoxification assessment and because the man wanted pain relief for his right hand which he had broken some weeks earlier. The GP said at interview that the man declined the medication offered to him for detoxification but accepted a prescription of five days of dihydrocodeine for pain relief for his hand injury.

20 OCTOBER 2004

During the morning of 20 October, the man attended the first stage of the induction programme which all newly arrived prisoners are required to undertake. During this stage he was seen by a range of people to assess his needs and to give him information about processes and procedures at Durham.

In discussion with a PO and an SO the man said that he had family support and expected to receive visits. He again declined drug detoxification support. The PO said at interview that the man was pleasant and seemed in good spirits.

Due to the fact that the man was a potential life sentence prisoner, he was seen the Lifer Manager who was accompanied by another officer. The man said that he expected a life sentence, but also said that he had been in prison so many times that a further prison sentence was of little consequence to him. He felt that his many previous years in prison custody would stand him in good stead and, whatever sentence was coming to him, he would get through it. The Lifer Manager recorded that there was no indication of suicidal ideation and that no additional support was identified as being required at that time. The man was aware of the support network available to him should circumstances change. When the Lifer Manager explained about the support available from Samaritans and prisoner Listeners (prisoners trained by the Samaritans), the man smiled and said that would not be necessary.

The officer who was present when the man saw the Lifer Manager said that he had known the man a long time. He described the man as a person who never showed emotion, a man who seemed not to want to talk to prison officers and who did not have much interaction with other prisoners either. The man was not a person who he would have suspected as likely to commit self-harm.

Following an automatic referral for detoxification assessment made during the man's reception screening, he was seen on 20 October by a CPN in substance misuse. The CPN in substance misuse was accompanied by an officer whose role is to monitor

prisoners going through drug detoxification. The man said that he used heroin on a daily basis and was also being prescribed dihydrocodeine and diazepam by his GP. He reported that he was suffering mild withdrawal symptoms. The man's GP practice was subsequently contacted by telephone and it was found that he was not in fact receiving any prescribed medication. The man requested methadone, but the CPN in substance misuse told him that methadone was only prescribed for people who had an existing prescription for that drug. The man was therefore offered lofexidine or symptomatic relief, but the man refused, stating that he would prefer to 'do his rattle on his own' rather than use lofexidine.

The CARATs (drug advice service) worker also attempted to interview the man during the morning of 20 October. At interview with the investigation team she recalled that when she went to the waiting room to collect the man she found him lying on the bench. She told him who she was and asked him to come with her for interview. The man said that he did not want to see her. He said he knew she was a CARATs worker and said that he did not want help from that service. The CARATs worker explained that for reasons of confidentiality she would like to speak to him on a one-to-one basis rather than in a public area; but he still declined to go with her. She informed him what CARATs was about and that if he would like a referral to the team at a later date he would only need to put in an application. The CARATs worker described the man's demeanour as arrogant, but said there was nothing about him to cause her any concern.

The Chaplain said that he went to see the man in the waiting room but found that he had gone back to his cell. The Chaplain went to the man's cell and explained that he had to see him to check on his religious registration, which had been recorded as Muslim. The man replied that that was correct and the Chaplain asked him if he was aware of the arrangements for Ramadan, to which the man replied that he was. The Chaplain told the investigation team that the man had initially been curt, but he had then calmed down.

21 OCTOBER 2004

During the morning of 21 October, the man attended the second stage of the induction programme with an induction officer. At interview, the induction Officer explained that in this session prisoners are taken through domestic matters: the arrangements for visits, mail, property, meal-times and choosing meals. Prisoners are also informed about policies and services such as race relations, anti-bullying, Samaritans and suicide awareness. The induction Officer could not recall the man and could not recall whether she saw him on a one-to-one basis or whether he was one of a group.

At around 1.45pm, the man's cell mate, was taken by the first Officer from the cell to go on a social visit. When he left the cell, the cell-mate recalled that the man was lying on his back on his bed. The first Officer relocked the cell door.

At about 2pm, cells were unlocked for 'downtime', to allow prisoners have showers, to make telephone calls and associate with other prisoners. The prisoner who met the

man in reception said that he had not seen very much of the man following their arrival. However, when cells were unlocked for downtime at about 2pm on 21 October, the man's door was open, so the prisoner went into the cell and asked the man if he was coming out. The man was lying face down on his bed and did not speak. The prisoner thought that the man might have been asleep and so he left the cell.

The PO who had seen the man on 20 October for a reception board was also on duty in C wing on 21 October. The PO believed that she saw the man out on the wing during downtime, although she could not recall having any conversation with him. The first Officer returned to C wing at just before 3pm, by which time downtime had finished and prisoners had been locked back into their cells.

THE DISCOVERY OF THE MAN'S DEATH

The first Officer was unlocking cells on C3 landing for prisoners to receive medication. The first Officer recalled glancing at his watch as he unlocked the man's cell. The time was 3.30pm. The man was lying face down on the bottom bunk and as the first Officer stepped further into the cell he saw a ligature, an electrical flex, around the man's neck and attached to the underside of the upper bunk. The first Officer immediately shouted for assistance. The first Officer said the second Officer arrived within seconds and between them they supported the man's body while an SO and another officer released the ligature from the upper bunk. The officers lowered the man's body to the floor and the second Officer cut the ligature from around his neck using a pair of scissors that had been handed to him.

The Staff Nurse had heard an officer shouting for assistance and, at the point that he reached the man's cell, he saw officers supporting the man's body and other officers trying to release the ligature from the wire mesh of the upper bunk. The Staff Nurse attempted to untie the end of the ligature that was around the man's neck, but he was unable to untie the knot. Instead, the ligature was cut away with scissors.

As soon as the man was lowered to the floor, the Staff Nurse began to assess him. The man was unresponsive to painful stimuli, he was not breathing, his heart had stopped, his pupils were fixed and dilated and he was cyanosed (cyanosis is the turning blue of bodily extremities following death). The Staff Nurse began mouth to mouth breathing while another nurse started chest compressions. Other nurses arrived from healthcare with the emergency response kit. The Staff Nurse and another nurse continued with CPR (cardio-pulmonary resuscitation) until the ambulance paramedics arrived at 3.50pm to take over. The paramedics were unable to resuscitate the man and the duty doctor pronounced the man dead at 4pm.

The attempts at resuscitation in the man's case were particularly traumatic and the Staff Nurse's efforts are worthy of commendation.

AFTER THE MAN'S DEATH

The duty governor arranged with the police for them to visit the man's mother to inform her of her son's death. Once the police had confirmed that the man's mother had been informed, the duty governor telephoned her to offer condolences on behalf of Durham and to give her contact telephone number as a liaison point.

The duty governor also arranged for the man's brother, who was in custody at HMP Liverpool, to be informed.

When the man's mother was visited by PPO staff on 6 December 2004, she said that Durham had not sent her a letter of condolence nor had she been offered assistance with her son's funeral expenses. The PPO took up these matters with Durham, following which a letter of condolence was sent and financial assistance given.

LEVEL OF COMPLIANCE WITH AUTHORISED PROCEDURES

The man was not the subject of F2052SH procedures at the time of his death. Nevertheless, all procedures for dealing with at risk prisoners were checked and found to be in accordance with laid down national guidelines.

The local policy documents for the care of prisoners at risk of self-harm and the protocol for the operation of the Listener scheme were comprehensive. However, the policy has not been signed by the Governor and Area Manager as required under PSO 2700.

As part of programmed Prison Service audit arrangements, the Standards Audit Unit conducted an audit in November 2002. Durham's prevention of suicide and self-harm procedures were rated as acceptable.

The minutes of Durham's prevention of self-harm and suicide committee for the preceding six months were examined. The committee was found to have been active, for example, by carrying out checks on F2052SH documentation. The meetings were well attended by a multi-disciplinary team including prisoner Listeners and representatives from the Samaritans.

Staff suicide awareness training records were examined and the available documentary evidence indicated many staff were out of date for suicide and self-harm awareness training. Durham's local suicide prevention policy requires staff to be trained at least once every three years. We have made a recommendation on this matter.

Self-harm response kits are available in every wing office, prominently displayed and appropriately sealed with contents lists attached.

CONCLUSIONS FROM CLINICAL REVIEW

There are a number of significant features in this case:

1. The man was accused of murder.
2. The record indicates that his previous sentence was life[1].
3. He had no fixed abode.
4. He refused to take a telephone PIN card.
5. He was detoxifying from significant amounts of heroin and benzodiazepine.
6. He denied feelings of self harm to everyone he whom he spoke.

A murder charge is recognised as a risk factor for suicide and if, as the record indicates, he previously had a life sentence, he would know that he faced a long future in prison.

The lack of any fixed abode and the wish not to contact family represents another risk factor, but was not referred to in the clinical record. It would be helpful in future to ensure that information of this kind, elucidated by non-clinical staff, is recorded in the clinical record and mentioned to clinical staff.

The man was detoxifying relatively rapidly. Rapid detoxification has been linked with deaths in young men.

In my view, there were sufficient risk factors present to sound alarm bells, despite the repeated denial of feelings of self harm. In hindsight, his admission to healthcare and/or the opening of an F2052SH with subsequent mental health review would have represented a safer option.

Having noted that, making these judgments in the short time frame available in a busy local prison reception can be notoriously difficult and I do not believe that anyone behaved negligently.

[1] *this is not correct*

FINDINGS AND CONCLUSIONS

The man gave himself into police custody on 17 October 2004, confessing that he had killed his girlfriend. He remained in police custody until midday on 19 October, when he was remanded into Durham. The PER form passed to Durham from the police indicated that the man was not perceived to be at risk of suicide or self-harm.

During his reception interview, the man said that he had family support and expected to receive visits. However, he refused a PIN number which would have enabled him to use the telephone.

The RMN, a psychiatric nurse with over 20 years' experience, carried out the man's health care screening interview. The RMN was aware of the man's charges and took those into account when making his assessment.

There is no agreed local policy available to nurses in reception regarding guidance on the issue of admission to healthcare of prisoners charged with murder, so the RMN appropriately contacted the Charge Nurse. The RMN was advised that that there was no need to automatically admit the man into healthcare, but should admit him if he wished to be admitted or if the RMN thought there was a need for admission. The RMN asked the man about being admitted to healthcare, but he declined. Additionally, there was nothing about the man's demeanour to give the RMN cause for concern. Another prisoner recalled hearing the man decline the invitation to go to healthcare. The RMN made no note in the man's records, however, that he had been offered and had declined admission to healthcare.

The man was not referred to a CPN for a psychiatric assessment, as was required by the criteria set out in Durham's First Reception Health Screening Form: the relevant criterion in the man's case being that he was charged with murder.

The man reported that he used heroin on a daily basis and that he was taking prescribed Benzodiazepines. Following a referral to the detoxification team, the man was seen by a CPN in substance abuse on 20 October. However, the man declined the detoxification medication offered to him saying that he would 'do his rattle on his own' without lofexidine.

The man was seen and spoken to by many staff during his three days in Durham, during his initial reception and then in connection with his induction programme. On no occasion did the man display any signs to suggest he was at risk of self-harm or suicide. He had many opportunities to voice any concerns he might have had for his wellbeing, but he did not do so.

The man had been allocated a shared cell in the first night/induction Unit. His cell-mate said that the man did not speak much but he did say that he had murdered his girlfriend. At about 1.45pm on 21 October, the cell-mate was taken from their cell to go on a social visit and the cell-door was relocked leaving the man alone.

A prisoner who met the man in reception on 19 October was located in the cell next door to the man's. The prisoner recalled the landing being unlocked for downtime at around 2pm on 21 October. He popped his head round the door on his way past the

man's cell and asked if he was coming out but the man did not answer. He was lying face down on his bed and the prisoner left him alone. The prisoner said that the landing was locked away about 40 minutes later when downtime ended.

When the man's cell-door was relocked after downtime, he was still alone as his cell-mate had not returned from his social visit. At about 3.30pm, the man's door was unlocked for him to get his medication. The man was discovered to be hanging by a ligature made from a television power cord that he had attached to the underside of the upper bunk. Staff responded quickly and professionally in trying to revive the man and paramedics were at the scene within 20 minutes. Unfortunately, the efforts made to resuscitate the man proved unsuccessful. No suicide note was found in his cell.

The clinical reviewer has pointed out a number of risk factors surrounding the man's circumstances: one was his refusal of a PIN number, another was the fact that he was detoxifying from drugs and had elected to do so without the medication offered to him. A further risk factor was his offence – not only an offence of murder, but his victim was a loved one. The clinical reviewer concluded that in hindsight, the safer option would have been to admit the man to healthcare and/or to open an F2052SH with a subsequent mental health review. While I can understand the clinical reviewers sentiments, I also note that the man was offered a place in healthcare by the RMN; an offer which the man declined to take. Moreover, in his brief time in Durham the man gave no indication that he was in distress. When asked about thoughts of self-harm or suicide, he said that he had no such thoughts and he also said that his many years spent in prison would stand him in good stead for whatever sentence would be coming to him for his latest offence.

After the police had visited the man's mother to break the news of her son's death, the duty governor telephoned her on behalf of the prison. During their conversation, the man's mother said that she had known her son would kill himself and she had thought about telephoning the prison to inform them of this. The man's mother said the same to the PPO staff when they visited her on 6 December 2004. Since the man's death, the Prison Service has issued guidance further to Prison Service Order 2710 which advises that the preferred choice for breaking the news of a death in custody is for the family visit to be made by prison staff.

The duty governor had further contact with the man's mother and other members of the extended family over the following days. Durham's death in custody contingency plan states that a letter of condolence offering sympathy from the Governing Governor should be sent to the family within three days of a death. The letter of condolence sent to the man's mother by Durham's Deputy Governor was dated 8 December 2004. This was seven weeks after the man's death and only after the PPO had reminded Durham of its omission. Similarly, it was only when reminded by the PPO that Durham offered the man's mother assistance with funeral expenses.

RECOMMENDATIONS

We make the following recommendation:

HEALTH

1. The PCT and Head of Healthcare should review Durham's healthcare admission procedures for those charged with murder, and ensure they are available in reception for those undertaking health screening of prisoners received into the prison.

> Prison Service Response:_*Recommendation accepted. All new receptions are seen by healthcare staff in reception. A full medical screening is undertaken to ascertain the needs of the individual. This is done in conjunction with Cell Sharing Risk Assessment Form. The decision where to locate is then made.*

2. The PCT and Head of Healthcare should develop a clinical audit system for the audit of First Reception Health Screening to ensure compliance with local and national policies and procedures.

> Prison Service Response: *Recommendation accepted. An audit of First Reception Health Screening will take place on a monthly basis with 10% of screenings being audited.*

3. The Governor and PCT should ensure that all sections of the First Reception Health Screening Assessment are completed fully on all occasions, with sufficient documentary evidence of decisions taken and any significant clinical issues noted in the prisoner's medical record.

> Prison Service Response: *Recommendation accepted. As per recommendation, this is now carried out as a matter of routine upon arrival of new receptions.*

OPERATIONAL

4. The Governor should ensure that letters of condolences are sent to the next-of-kin within three days, as required by Durham's contingency plans. The Governor should also ensure the latest Prison Service guidance is followed in connection with the offer to bereaved families of payment of funeral expenses.

> Prison Service Response: *Recommendation accepted. This task is now carried out by the Safer Custody Team, in liaison with the Governor. This is in conjunction with PSO 2700 and local contingency plans.*

5, The Governor should consider a rolling training programme for refresher training for staff in suicide and self-harm awareness, in accordance with Durham's own local policy on this issue.

> Prison Service Response: *Recommendation accepted. A full staff refresher training programme is in progress, with all staff to be retrained by April 2006. This is to coincide with the implementation of ACCT (which is to replace the F2052SH system for monitoring prisoners judged at risk of self-harm).*

RECOMMENDATIONS ON STAFF PERFORMANCE

6. The caring and dedicated attitude displayed by the Staff Nurse in attempting to resuscitate the man is particularly worthy of recognition by the Governor.