# Investigation into the circumstances surrounding the death of a man at HMP Holme House on 7 January 2006

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

**March 2007**

This is the report of an investigation into the death of man at HMP Holme House on 7 January 2006. Just after 5.00 am that morning, the man was found with a ligature tied around his neck and attached to the top of the bedstead in his cell in the healthcare centre. The man had been sentenced to eight years imprisonment on 16 December 2005. He was 67 years old.

I took over responsibility for investigating deaths in prison custody in April 2004 and this was the third apparently self inflicted death that I have investigated at Holme House. The purpose of my investigation was to establish the circumstances and events surrounding the man's death, including the quality of care provided by the Prison Service. The investigation was led by Two investigators from my office. I commissioned a clinical review from North Tees Primary Care Trust and I am most grateful to the clinical governance lead at the Trust, for supplying a detailed medical report.

I thank the Governor of Holme House and his staff for the co-operation my investigators received at all stages of the investigation. They were greatly assisted by the prompt way in which the liaison officer carried out his duties. I also thank the Detective Sergeant of Cleveland Police for the assistance he gave to my investigators.

One of my investigators and one of my Family Liaison Officers, met with the man's son and daughter-in-law. They asked for a number of questions to be addressed in the course of the investigation. The family liaison officer spoke on the telephone to the man's partner and she also raised concerns for me to consider. I have endeavoured to deal comprehensively with all their questions in my report. I offer my sincere condolences to the man's family and friends.

The man had never been in prison before. In the documents annexed to my report there are numerous references to 'bizarre', 'distressed' and 'challenging' behaviour. It appears that the man's acute distress was attributed to manipulation or his withdrawal from the large amounts of alcohol he had drunk over decades. He was not seen by nurses from the prison's integrated mental health service until the day before his death, by which time he had been held at Holme House for three weeks. I have made a number of recommendations designed to improve systems and procedures at Holme House but I also comment on some highly commendable staff responses and behaviour. I am pleased that all the recommendations made in my draft report and in the clinical review have been accepted.

**Stephen Shaw CBE**
**Prisons and Probations Ombudsman** **March 2007**

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**Summary**

A man was found hanging in cell HA1-5 in the healthcare centre at HMP Holme House at approximately 5.00 am on 7 January 2006. The man had never been in prison before but was sentenced to eight years imprisonment on 16 December 2005 for serious sexual and violent offences. On arrival at Holme House that afternoon, he was located in the healthcare centre overnight then started an alcohol detoxification programme the next day.

During the three weeks the man spent at Holme House, he had numerous cell changes and his behaviour was described as disturbed and bizarre by many observers.

On 29 December, the clinical nurse manager at Holme House contacted the man’s GP in relation to his “recent strange behaviour.” The nurse manager told the GP that the man could appear to be quite lucid but then his behaviour would change and he would become rude and abusive. The nurse manager recorded in the man’s clinical record that the GP told her that this behaviour was quite usual for the man and he would use “any means to manipulate to get what he wants.”

The man flooded his cell in the healthcare centre on an almost nightly basis. On 1 January 2006, control and restraint techniques were used to transfer him from the healthcare centre to a special cell in the segregation unit because the man had flooded and smashed up his healthcare cell. At a disciplinary hearing on 2 January, the man was accused of offending against Prison Rules by intentionally endangering the health and safety of himself and others. It was alleged that he had flooded, urinated and defecated on the floor of his cell.

On 3 January 2006, the man was transferred to Houseblock 3 which is used to house vulnerable prisoners and new receptions. The man had already applied to be segregated from other prisoners due to the nature of his offences.

Soon after the man’s arrival on Houseblock 3, an officer wrote in the record of events section of the man’s prison record that he was agitated when unlocked for teatime. He said that people were in the exercise yard wanting to kill him and shouting at him. At 6.00 pm the same afternoon, a regular landing officer on Houseblock 3, noted continued bizarre behaviour. He answered the man’s cell bell and the man asked the officer for help because ‘’them on the yard were going to get him.’’ The regular landing officer recorded that there were no prisoners on the yard at that time.

On the morning of 6 January, the regular landing officer urgently referred the man to the mental health team at the prison. Two experienced mental health nurses saw the man the very same morning and decided that he should be seen by a visiting psychiatrist three days later. The man was transferred from the segregation unit to cell HA1-5 in the healthcare centre. That was a camera cell but during the night of 6 to 7 January the camera did not work effectively until approximately 5.00 am. At that time an Operational Support Grade (OSG) who was on night duty in the healthcare centre with a Nurse, noticed that the man seemed to be “a funny colour.” He was lying on his bed but had attached a ligature made from a sweatshirt to the headboard

of his bed.  The two women were joined by two male colleagues and strenuous efforts were made to revive the man, but without success.

The prison sent a recently trained Family Liaison Officer (FLO) to inform the man's partner and her family of his death.  The man's son, a serving officer at a prison near London, rang Holme House during the afternoon of 7 January to obtain more information about his father's death.  Regrettably, the son was given no additional information about his father or the circumstances of his death until two days later.

I make several recommendations and attach particular importance to the recommendation relating to a more robust FLO system in the North Eastern prisons. I am very disappointed that the man was not referred to the mental health team at Holme House until the day before his death despite the high levels of confusion and distress that he had been displaying for many days before then.

**The investigation process**

1. This investigation was undertaken by two investigators from my office. They issued notices to staff and prisoners, telling them of the investigation and its term of reference and offering them the opportunity to participate.

2. They visited Holme House on a number of occasions and interviewed staff who had especially significant relationships with the man. They reviewed all relevant documentation and visited cells where the man had been held, both in the healthcare centre and segregation unit. They met with the detective from Cleveland police leading the investigation into the man's death.

3. My Family Liaison Officer arranged a meeting with the man's son and daughter in-law which was attended by herself and one of my investigators. My investigators conducted interviews both at Holme House and the prison in which the son worked. This was in response to his complaints about the treatment he received when he rang Holme House, on the afternoon of 7 January, to obtain information about his father's death. The family liaison officer spoke to the man's partner, on the phone. The partner said she was concerned about the man's alcohol detoxification programme, the healthcare he received in prison and that his victim had been told of his death before the family.

4. I commissioned a clinical review about the circumstances of the man's death from North Tees Primary Care Trust. The review was undertaken by a clinical reviewer.

5. No pre-sentence report was written at the time the man was sentenced and my investigators endeavoured to obtain reliable information about his life in the community. They made telephone contact with the experienced criminal lawyer who had represented the man at his trial and I am most grateful for the information he supplied. They also wrote to the Crown Prosecution Service in Middlesbrough but received no response. A response to The clinical reviewer's report was invited and received from the locum medical officer at Holme House.

6. My investigators studied the reports on previous self inflicted deaths at Holme House in 2002, 2004 and on 5 March 2005. They obtained advice on the medical fitting of prisoners for adjudications from the policy lead on this subject at the Offender Policy and Rights Unit in the National Offender Management Service.

## The man

7. The man was 67 years old at the time of his death. Although he was sentenced to eight years imprisonment at Teesside Crown Court on 16 December 2005, no pre-sentence report was written at the time. There is, therefore, only a limited amount of documented biographical information about him.

8. Some information about the man's life in the community before his sentence is contained in the mental health assessment report written by two Nurses on the morning of 6 January 2006. They wrote that the man had drunk heavily for many years and that his wife had died 20 years previously after 30 years of marriage. The man told the nurses that he had worked as a crane driver but stopped working when his wife died. He was described as retired on his core prison record.

9. My investigator spoke to the experienced criminal lawyer who represented the man at his trial. The lawyer explained that, if he has concerns about the possibility that one of his clients will self harm, it is his practice to warn the staff who are escorting his client to prison. The lawyer had no concerns at all that the man would self harm and thought he would settle well in prison once his alcohol detoxification was complete.

**HMP Holme House**

10. Holme House is situated in Stockton on Tees, Cleveland, and is a category B local prison for unconvicted, convicted and sentenced male adults. The prison primarily serves the communities of Tees Valley, South West Durham, East Durham and North Yorkshire. The prison opened in May 1992 and its operational capacity (the maximum number of prisoners who can be held there) is 994.

11. Her Majesty's Chief Inspector of Prisons, inspected Holme House in April 2005 and issued her report three months later. In the introduction to her report, she wrote that her inspection recorded some extremely good work in detoxification and healthcare. She added that "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 the staff."

12. In the section of her report dealing with self harm and suicide, The inspector wrote that five prisoners committed suicide at Holme House in 2002. She noted that Holme House had been one of the pilot sites for the Prison Service's new Assessment, Care in Custody and Teamwork (ACCT) approach to managing prisoners at risk of self harm. The inspector observed approvingly that the mental health in-reach team had run sessions for staff and Listeners (prisoners trained to assist their fellow prisoners at times of crisis) to raise awareness of mental health issues.

13. Soon after my investigation began, the Governor transferred from a nearby young offenders' establishment to become governing Governor at Holme House.

**The man's initial health screen on 16 December 2005**

14. On the afternoon of Friday 16 December 2005, the man was sentenced to eight years imprisonment at Teesside Crown Court for offences of rape and assault. The man had been on bail until the time of his sentence and he had not been to prison previously. He was escorted from court to Holme House by staff working for Global Solutions Limited, a private escort company. The front page of his Prisoner Escort Record (PER) highlighted his medical condition and his conviction for a sexual offence. Escort staff wrote at section 5 of the PER form "DP (detained person) states that he has a heart condition – medication with DP."

15. Section 4 of the PER form has a column devoted to risk categories other than medical and security. This column includes 'drugs/alcohol issues' and the perceived risk of suicide or self harm. Neither of these categories were thought to be relevant in the man's case and at the foot of the column the heading 'no known risk' was ticked.

16. During the reception process at Holme House a number of personal details about the man were recorded on the first page of his core prison record. He indicated that he had been living at an address in Hartlepool. He stated that his next of kin was his partner who lived at the same address. The man told prison reception staff that she was the person to be contacted in an emergency.

17. The health of all newly received prisoners at Holme House is screened and the information obtained during that process is recorded on a first reception health screen form. In the man's case, the nurse who carried out the reception health screen was an experienced Registered Nurse. The man told the nurse the name, address and telephone number of his GP in Hartlepool. He said he had not been in prison before and that he had seen a doctor in the last few months due to his high blood pressure. He said that he was receiving medication for hypertension and his only other physical health concern at the time was an ingrowing toenail on his right big toe.

18. In answer to questions about alcohol use the man said that he drank socially, consuming six to seven pints of beer daily. When asked about the timing of his most recent drink, he replied that it had been the same morning.

19. On arrival at a local prison such as Holme House all prisoners are asked a series of questions about mental health. The man told the nurse that he had never received treatment for any form of mental health problem. He said he had never received medication for his nerves and had never tried to harm himself. As is routine, the nurse explained that coming into prison can be difficult for some people, with a few finding it so hard that they may consider harming themselves. The man was asked if he felt like that or even suicidal and he answered no to both questions.

20. At the end of the first section of the form, the nurse wrote that because of the man's length of sentence and his age he should be placed in the healthcare

centre overnight. In the second part of the form, headed ‘secondary health assessment’, the nurse recorded the man’s blood pressure and in the ‘planned action’ section, at the end of the form, she recorded her decision that the man should be referred to the prison doctor.

21. My investigator interviewed the nurse and discovered that she had qualified as a Registered Nurse in 1977 and had practised continuously as a nurse since that date. She worked as a sister on the Accident and Emergency (A and E) ward at North Tees Hospital for about 25 years, and then started working at Holme House about 18 months before the man’s death.

22. The first reception health screen form states that, if a new prisoner has been drinking more than about 20 units daily (the equivalent of ten pints of beer or cider or half a bottle of spirits) or is showing signs of withdrawal, the nurse should hold a discussion with the doctor and consider admission to healthcare for observation. The man was underneath that threshold as he told the nurse that he drank six to seven pints each day. My investigator asked if the nurse had concerns about the way the man was presenting or about possible alcohol withdrawal. She replied that she had no alcohol related concerns at all about him.

23. My investigator asked the nurse if the man seemed low or depressed in view of the lengthy prison sentence he had just received. She replied that he had said “I don’t suppose I’ll ever get out of here” but, to her, he seemed “quite chirpy, quite intelligent and he didn’t seem depressed.” The nurse explained that she put him in the healthcare centre that evening “because of his age and because of the length of his sentence, not because I was worried about him.” Later in the interview, the nurse added that she expected the man to remain in the healthcare centre for just one night so that he could see the doctor. She anticipated that he would then be moved to another houseblock.

24. The nurse told my investigator that the man was not the usual type of prisoner she encountered because “he was intelligent, he was easy to talk to, he spoke quite well and he just seemed a very nice gentleman.”

25. The nurse emphasised that there were no signals whatsoever that made her concerned about the man in relation to alcohol detoxification and withdrawal. She confirmed that, as a result of her long experience in A and E medicine she was very familiar indeed with people presenting in front of her who had significant alcohol problems. My investigator asked the nurse a number of questions about the possible risk that the man would self harm. She answered that she had no concerns at all and, when asked to explain why, she said:

> “He was calm, spoke very intelligently, came across as a very intelligent gentleman. First time in prison but no concerns whatsoever about him at all. Between the two of us, the relation was quite good, his communication was very good, he didn’t stammer, stumble, anything all his questions were answered clearly and concisely and he just came across as a very intelligent man.”

26. On 16 December, the man also completed a form requesting that he be located on the vulnerable prisoner unit on Houseblock 3. The form indicated that his offence was rape and he wrote that he wanted protection "for my own safety." The man was not actually transferred to Houseblock 3 until 3 January 2006 as his stay in the healthcare centre turned out to be much longer than the nurse had predicted.

**The man's 'confused and bizarre' behaviour**

27. Although there were no concerns about the man on Friday 16 December, that situation began to change as soon as the following day. For the last three weeks of the man's life there were numerous expressions of concern about him, recorded in a number of different documents. He was frequently very noisy and staff used adjectives such as "strange", "bizarre" and "confused" to describe his behaviour.

28. On 17 December, the medical officer noted in the man's clinical record that it was his first time in prison and that he had received an unexpectedly heavy sentence. He was feeling a bit low but had no past history of depression or self harm and denied any thoughts of self harm. The next entry in the clinical record, also dated 17 December, stated that the man was found to be tremulous and very anxious. He was now giving information that he drank quite heavily, consuming two and a half bottles of cider daily. In response to his alcohol withdrawal, the doctor prescribed a reducing daily dose of chlordiazepoxide (brand name Librium – used to treat anxiety) which began at noon on 17 December and ran until 27 December 2005.

29. On Sunday 18 December, a further entry in the clinical record referred to a review that morning. The notes continued:

> "Claims he heard women singing last night - that unsettled him. Found to be a little paranoid this morning – refused to take his medication. Was eventually convinced to take his Librium."

30. A lengthy entry on a care plan/pathway continuation sheet also dated 18 December states:

> "Appeared confused and deluded at beginning of duty today thinking people were drilling into his cell from adjacent cells and that a woman was singing in his cell… Seen by MO (medical officer) mid-morning and was less confused. Medication changed… Staff to monitor for any disorganised behaviour/ paranoia / hallucinations."

31. The man had initially been located in cell HA1-5 which is on the ground floor in the inpatient section of the prison's healthcare centre. At 11.00 pm on the evening of 18 December, a Nurse recorded in the clinical record that the man had been relocated to cell H1-23 after smashing all the furniture in cell HA1-5 and setting fire to his bedding. The man told staff he was about to be murdered and that they needed to send for the police and the doctor. He refused to take his chlordiazepoxide "as it is poison." One of the prison doctors was contacted and expressed concerns that the man might fit due to his alcohol detoxification. He was "to be on constant obvs (observation) in camera cell". (Some of the cells in the inpatients unit have camera cover with pictures being transmitted to a screen in the nurses' office.)

32. Cell H1-23 is a camera cell but the man was not put on constant observations as Holme House does not have a policy for constant observation.

**I recommend that the Governor should consider whether a policy on constant observations, especially in camera cells, should be drawn up.**

33. Two other entries were made by a nurse in the clinical record during the early hours of Monday 19 December. The entry at 2.00 am notes that the man:

> "Continues to shout, scream and bang. Cell flooded with water – same turned off by Orderly Officer. Constant use of cell bell, but does not want anything."

34. A further entry at 3.10 am observed that the constant banging and shouting was continuing. The man was now shouting that he had been murdered by "four security officers, three nurses, a journalist and Santa Claus." His mattress looked as though it had been ripped in half.

35. On 21 December, entries in the man's prison record (F2052A, record of events booklet) state that he was lying on the cell floor behind his cell door. He had excrement all over his lower body and excrement could be seen on the walls and table. The man did not respond when staff spoke to him but he was moving around the floor, "spreading his bedding about." At 11.00 am that morning, he was moved to cell number 1 after having a bath.

36. The next entry in the record of events booklet, also known by the staff as the history sheet, was made by an Operational Support Grade (OSG) on 23 December. She wrote:

> "A settled day, polite to staff but remains paranoid thinking someone can get into his cell to abduct him. Have assured him this cannot happen."

37. On the morning of 24 December yet another cell change took place, with the man being moved to H1-5, the camera cell he occupied when he first arrived at Holme House. The entry in his clinical record states that he was relocated after smashing a table in his cell overnight. He walked to the new cell without any difficulty or problems and accepted his morning medication, again without any problems. At 10.00 am on 24 December he was seen in the camera cell by the medical officer who wrote "appears confused and complaining of hallucinations. Has infected toe … to remain in safety cell."

38. The OSG undertook a week of night duties in the healthcare centre beginning on Monday 19 December and she was again on night duties on the inpatients landing during the week beginning Monday 2 January 2006. On 19 December, when she first saw the man, she said he did not know where he was or what was happening to him. She said she stood and talked to him for quite a while, trying to explain to him how to work his taps, and she gave him regular cups of water while he was awake. She explained that he did not go to sleep but used to sit on his bed or lie on the floor. He had his mattress and possessions on the floor. The OSG said she spent quite a lot of time with the man that week "because I thought he was poorly off the alcohol" and she was

endeavouring to reassure him. She recalled that he warned her he would blow the television up if she tried to enter his cell. By the end of the seven nights the OSG thought that the man was coming round to realising that he was in prison. She thought he understood that she and her nursing colleague that week were keeping him safe and no one was going to get him. Her recollection was that on seven nights out of seven he flooded his cell. She would then call for the night orderly officer (the officer in charge of the prison during the night) to come in order to turn off the water and electricity supply to his cell. This could be done from a panel in the corridor just outside the man's door.

39. The OSG made some long entries in the hospital observation book about the man's behaviour on 24 and 25 December. At 11.00 pm on 24 December, the OSG wrote:

> "For approx 2 hours the man has had his TV on very loud. He has water over the door and floor. He says if anyone goes in to kill him he will blow the place up. He says that I am a witch and wouldn't turn the TV down until he had a note saying he will be safe until 7 am."

40. An entry at 2.30 am on Christmas Day noted that the TV was back on loud and the observation window in the cell door was covered in soggy bread. The man started to throw water around his cell and the night orderly officer turned off the water and electricity. The man was "playing the drums with broken table legs."

41. A further entry by the OSG on Christmas Day says:

> "The man has had his water turned off as he started to flood the cell again. He has handed over 3 cups which he was using to bang on pipes. Has not slept at all and at approximately 4.00 am started to bang on the door with his shoes claiming someone wants to kill him and will break in his cell by drilling from next door."

42. On 28 December, an Officer made an entry in the record of events booklet. The officer wrote that he had interviewed the man as part of an attempt to deliver an induction package. As he was located in the healthcare centre, the man had missed out on the induction package routinely delivered to prisoners who transfer directly to a residential houseblock. The officer declared he was happy with the man's general well-being but:

> "Could not really make any progress re induction package due to apparent mental health issues and delusional behaviour."

43. Again on 28 December, the following entry was made in the care plan/ pathway continuation sheet:

> "Confused at tea-time, put his tea in the sink. Praying to a cross he made on the floor. Convinced the staff are going to hurt him, reassured and he stated thank you for helping and talking to him.

Denied any thoughts of self harm, remains on frequent/irregular observations."

44. On 29 December the clinical nurse manager at Holme House, contacted the man's GP in Hartlepool by telephone. The clinical nurse manager made a lengthy entry in the clinical record at 9.00 am:

> "GP contacted today regarding the man's recent strange behaviour. Explained how he appeared to be quite lucid but then behaviour would change where he became rude and abusive. I also informed him that he had undergone an alcohol detox regime. GP explained to me that this was normal behaviour for the man to use any means to manipulate to get what he wants. States he can be very charming when things were going his way. The man was prescribed Temazepam by his GP but it was suspected that he was selling them. I explained that we were concerned that there could have been something underlying but GP assured me that this was the man's normal behaviour."

45. In interview the clinical nurse manager said she had been a Registered Mental Nurse (RMN) for 30 years and had worked at Holme House for 12 years. She had recently completed a forensic mental health degree at the University of Teesside. Her work at the prison was mainly with patients who had mental health and substance misuse problems. Her concern about the man was triggered because:

> ''He'd gone through the detox, seemed as if he was doing fine, really well, then all of a sudden he'd start displaying signs as if he was having DTs again.''

46. Healthcare colleagues had reported to her that the man seemed to be in (alcohol) withdrawal again. She was surprised because '' you don't normally come out of withdrawal and then go back in it.'' She observed the man carefully and on the basis of that close observation decided to phone his GP.

47. When the GP told the clinical nurse manager that the man's behaviour was ''normal'' she decided to find out if there was any underlying organic reason for his abrupt behaviour changes. She instructed her colleagues to take blood samples so that Liver Function Tests could be conducted at North Tees Hospital. The clinical nurse manager wanted to know if the man had liver damage and wondered if he had an infection causing all his confusion. A Full Blood Count would establish whether the man was anaemic and fasting blood sugar would indicate whether he had diabetes. (Raised or low blood sugar levels, according to the clinical nurse manager, could have caused his confusion.)

48. A note in the care plan sheet for the same date stated that the man would be transferred to a residential houseblock the following day.

49. On Friday 30 December, an entry in the clinical record stated:

> “The man’s GP says he is faking his condition.  To stay in HC (healthcare centre) over weekend – transferred to HB (houseblock) on Tuesday.”

50. A more detailed account of the clinical response to the man on 30 December is set out on the care plan sheet.  There a nurse made an untimed entry on 30 December:

> “Seen by MO and nursing staff.  Continues to present as confused. Quite agitated and confrontational when challenged re-confusion. Remains in camera cell on frequent and regular observations.  His Doctor feels that sending him to the houseblock would be a problem over the weekend/bank holiday period – due to his behaviour he would return very quickly to healthcare.  He has been told he will be going to the houseblock first thing Tuesday 3 January.”

## The man's location in the segregation unit on 1 and 2 January

51. The man did indeed move to Houseblock 3 on 3 January 2006 but before he did so he was held in the segregation unit on 1 and 2 January. Through the night of 31 December to 1 January, the man was again very noisy and disruptive and there were fears that he would use violence against staff. A Nurse's note in the care sheet about the nightshift is untimed but it is likely that she wrote her account around breakfast time on New Year's Day. She observed:

> "Shouting his name, address and prison number. He is aware that he is in prison, and stated that it was New Year's Day. He has covered his face in faeces, and has made a weapon by placing his belongings in his pillowcase which he is swinging towards the staff when approached. He also has what looks like a crushed Marvel tin which he is using to try and hit staff on the hands when hatch is opened. He has upset all the other patients in healthcare with his incessant shouting and banging."

52. In her account in the record of events booklet, the Nurse added that the orderly officer (the officer in charge of the operational running of the prison during the day) was aware of the situation. In her entry in the hospital observation book, she also indicated that the man was hiding his pillowcase, with personal belongings inside, down the side of his toilet.

53. At approximately 8.30 am on the morning of 1 January, force was used to transfer the man from his hospital cell to the segregation unit. When authorised force is used, as in this particular movement, the staff involved are required to complete use of force forms. Five staff in total were involved in the use of force and each of these men completed the necessary statement.

54. The staff team was led by a Senior Officer (SO) from the security department at Holme House. In his statement on 1 January, the SO wrote that on the instructions of the orderly officer he attended the hospital and spoke to the man. He was flooding his cell and blocking his toilet and hand basin. He had a pillowcase in his hand with unknown items inside. The works department turned the water supply off and SO Dempsey then spoke to the man, who refused to comply with orders he was given. The SO's statement continues:

> "For his and staff safety he was removed and relocated to cell SA1-27. He was seen by the healthcare and reported no injuries. No injuries were sustained by any staff."

55. During the man's removal to the segregation unit, control and restraint (C and R) techniques were used. These are techniques, approved by the Prison Service, which staff are permitted to use in carefully limited circumstances where a prisoner has to be restrained or transferred from one location to another. During the man's removal, officers used approved techniques to control his head and each arm. An Officer wrote in his statement that he was part of the team involved in the man's planned removal. He said the man had

to be removed from cell HA1-5 due to the fact that he had flooded his cell, covered himself in excrement and was holding a pillowcase with unknown items inside and threatening to assault any member of staff who entered the cell. The officer took charge of the man's head and observed that the man "was at times non-compliant and a full relocation was required."

56. A Staff Nurse observed the planned move to the segregation unit and afterwards duly completed form 213 entitled Report of Injury to Inmate. At section 2b of the form the staff nurse reported that the man sustained no serious injuries during his planned removal from healthcare to the segregation unit using C and R methods. At section 3 of the form the medical officer wrote that no injuries were reported or seen when the man was examined at 9.30 am on 1 January.

57. When the man arrived at the segregation unit he was located in special cell SA1-27. A special cell is a cell in the segregation unit from which the usual items of furniture have been removed.

58. The man was the first prisoner at Holme House to be located in a special cell in 2006. The register of the use of special accommodation and mechanical restraints at Holme House indicates that they were deployed on just 15 occasions throughout the whole of 2005.

59. Form 2323, the form used when a prisoner is located in a special cell, shows that the man was located in cell SA1-27 at 8.30 am and removed from that cell at 2.35 pm on the same day. At 9.30 am the medical officer signed to confirm there was no medical reason why the man could not be located in the special cell.

60. At 9.45 am, the Governor authorised the man's location in the special cell. The reason given for this decision was:

> "Due to violent and abusive nature, normal clothing removed and to remain in current location. Clothing wet due to smashing up of cell and flooding of HA1-5."

61. The Governor instructed that the man must be observed every 15 minutes while he remained in SA1-27. On the reverse of the form, two Officers have made entries at 15 minutes intervals in the records of actions and observations. Many of these entries refer to the man pacing the cell and lying or standing on the plinth on the cell floor. The last entry in the record of actions and observations was made at 2.35 pm and comments on the man's removal from the special cell due to improved behaviour. He was given a shower.

62. The computerised record of the man's cell changes during his time at Holme House is inaccurate because it states that he remained in cell SA1-27 until 11.00 am on 2 January. A more reliable source of information is the segregation unit history sheet which comments at regular intervals on the 26 hours that the man spent in the unit. The history sheet shows that, at 2.30 pm

on 1 January, the man was given a shower then relocated to SA2-25 where he was given cardboard furniture. The night patrol officer commenced his duty at 7.30 pm on 1 January, and then made an entry at 1.00 am on the morning of 2 January. At that time the man "pressed the cell bell, asked when he could come out of his cell for association! Informed about seg routine." At 3.00 am, the man pressed his cell bell again and asked the officer how the radio worked in his cell. The man appeared to think that the air vent in the cell window was a radio. In the morning the man had breakfast and a shower. The last entry on the history sheet was made at 10.30 am. The man was seen at that time by a Governor and a Doctor. The decision was taken that he should return to the healthcare centre and the segregation history sheet was closed.

63. A segregation safety algorithm must be completed by a registered nurse or a doctor within two hours of a prisoner being placed in the segregation unit. Part A of the algorithm appears to have been completed by a doctor. The third question asks if the prisoner shows signs of being acutely unwell (for example psychotic). The answer given was 'yes' and, confusingly, both yes and no were ticked in response to the fourth question 'Do you think that the prisoner will be unable to cope with a period of segregation?' The Governor completed the form at 9.50 am and wrote that the man's removal had been planned due to a 'smash up' and attempted assault on staff. The Governor decided that the man was suitable for segregation and he supplied the necessary authorising signature.

64. On New Year's Day, the man had been charged by the Staff Nurse with intentionally endangering the health and safety of himself and others by flooding, urinating and defecating in his cell at approximately 8.00 am the previous morning. He appeared at adjudication on 2 January but no formal consideration seems to have been given to his medical fitness for adjudication as section 4 of the adjudication form (F256 record of hearing and adjudication) is blank.

65. The man pleaded not guilty to the charge and said he had not urinated or defecated on the floor though he had flooded the cell in an attempt to get out. The record of hearing does not clearly indicate whether the man made his points in response to the charge against him on 2 or 3 January nor does the record show whether the Nurse, who made the allegation against the man, was required to give evidence in person. The charge was found proved by a Governor on 3 January, with the man's punishment being stoppage of 50% of his earnings for a period of five days and forfeiture of a number of privileges for three days.

66. The man's clinical record refers to him being seen in the segregation unit on 2 January by a doctor. The doctor wrote that the man answered the questions coherently but then 'wandered' into a story about being captured by Scots and how they imprisoned him. The doctor ordered that the man should be observed for the present on the hospital wing. He noted that blood test results, commissioned by the clinical nurse manager, were due back on the

following day. Information supplied to me by Holme House is that these blood test results were never received.

**The man's time in Houseblock 3**

67. On 3 January, a doctor declared that the man was fit for adjudication that morning and also asked for an assessment by the 'dementia team' to be arranged. There is no signature by the medical officer at section 4 of the record of hearing and there is no written record of any communication between the medical officer and the adjudicating officer. An entry by a nurse on the care plan sheet reads:

> "Adjudication this morning, MO "fitted" on return may go to houseblock same done."

68. In a letter dated 6 June 2006 the doctor explained that he did not see the man during the two weeks between 18 December 2005 and 3 January 2006. On the latter date, he had a general discussion with the nurses and ''I felt he was fit for adjudication.'' It has not been possible to interview the doctor as he no longer works at Holme House.

69. The computerised record of cell moves indicates that the man spent two and a half hours in cell HA1-2 (in the healthcare centre) around lunchtime on 2 January before being transferred to cell HA1-5 for the next 24 hours. HA1-5 is the camera cell from which the man had been forcibly removed on the morning of 1 January. The computer record shows that he transferred from the healthcare centre to Houseblock 3 at 2.50 pm on 3 January.

70. As soon as the man arrived on Houseblock 3 he was located in cell B3-2 by the regular landing officer. The regular landing officer had contact with the man on a number of occasions on both 3 and 6 January and my investigators interviewed him at some length. The regular landing officer explained that he has been a prison officer for ten years and has been a landing officer on B wing in Houseblock 3 for the last year. He was the first point of contact the man had when he left the hospital and came to the houseblock. The regular landing officer explained what the wing routine would be but he felt the man "seemed a little bit vague as if he didn't really understand what I was saying."

71. Once the man was located in his cell, the regular landing officer recollected that he constantly rang his cell bell. The man was unlocked for the teatime meal by another Officer and the other officer made an entry about this in the man's record of events booklet. He said:

> "I unlocked this inmate for his teatime meal. He was a bit agitated saying people were in the exercise yard wanting to kill him, shouting at him and that he did not want to come out for his meal."

72. The regular landing officer said that, after the staff had served the teatime meal, the man constantly rang his cell bell "asking for strange, trivial things." Around 6.00 pm, the regular landing officer made an entry in the history booklet which reads:

> "Continued bizarre behaviour from this man, I answered his cell bell and he asked me to help him because "them on the yard" were "going to get him" (it is 6.00 pm and there is nobody on the yard) warned verbally about misuse of cell bells. I have contacted healthcare and spoken to the clinical nurse manager about the man. She told me that he has (emphasis in original) been referred to mental health services already. His behaviour needs to be monitored and recorded."

73. In interview, the regular landing officer explained that although he is not medically trained he had concerns about the man's mental health. He was asked by my investigator how many times in a ten year career he had been sufficiently concerned about a new prisoner to ring up healthcare. He estimated he had done this just six times in his career to date. He was asked what made him sufficiently concerned to ring healthcare and replied:

> "It was his behaviour, it was bizarre, the things he was saying didn't make sense. Obviously I am his landing officer so I was responsible for him and that was the reason that I phoned the hospital."

74. The regular landing officer recalled that the clinical nurse manager told him that the man had already been referred to the mental health services and his behaviour needed to be monitored and recorded.

75. When interviewed in February 2007, the clinical nurse manager was asked if she could recall why she told the regular landing officer that the man had been referred to mental health services. She agreed that she had not been looking at a document or a piece of paper which led her to say that the man had already been referred. The clinical nurse manager said:

> ''There was something in my head that said he'd been referred. I didn't have it in front of us, no.''

76. Earlier in the interview, the clinical nurse manager said she assumed that the man had been referred to her mental health colleagues. She added:

> ''For somebody with behaviour like that, I'd already seen him and done everything else, rightly or wrongly I've maybe assumed that it's been done. But that is the way it should have happened.''

77. In an email exchange with my investigator in July 2006, the clinical nurse manager wrote that on 3 January she was informed that the man had been referred already by the staff that were on duty. She was later informed that another Nurse was the referrer but it has not been possible to arrange an interview as the other Nurse no longer works at the prison nor indeed for North Tees PCT.

78. The regular landing officer went off duty at 7.45 pm on 3 January and his next duty on B wing was not until the morning of 6 January. In the intervening period, several different staff made entries about the man's bizarre and disruptive behaviour in the Houseblock 3 observations book, the record of

events booklet and a history sheet headed 'Induction/Resettlement interview' sheet.

79. The next entry in the record of events booklet was made by the OSG on 4 January 2006. The regular landing officer explained that the OSG was a night patrol officer who came on duty at 8.45 pm on 3 January. His entry reads:

> "This prisoner continues with his bizarre behaviour, constantly on his cell bell, banging his cell door, shouting at the top of his voice "stop them in the yard, they are going to kill me". A very disruptive prisoner, tried to speak to the man but he refused to speak."

80. A further entry made in the record of events booklet around breakfast time on 4 January states:

> "This prisoner is very disruptive to the wing routine. He has kept everyone up during nights and has received various threats to his safety. In my opinion he is not fit to be on any normal (emphasis in original) location within the prison."

81. When the SO came on duty on the morning of 4 January, he spoke to the man about his behaviour during the night. The man said he could not remember anything, but the SO warned him that if his disruptive behaviour continued he would be segregated. Later the same day, the man was again charged with an offence against the Prison Rules. In his report about the alleged offence, an Officer wrote that, at 8.00 am on 4 January, he recovered a torn bed sheet from the man's cell. It had been made into a 'line' which was attached to the window bars of the cell. Such 'lines' are often used by prisoners to transfer items to and from their cells during the times of the day when they are locked in. On 5 January, the hearing of the charge was adjourned until the following day because the man entered a plea of not guilty and the Officer was not on duty to give his evidence in person.

82. The single entry for 5 January in the man's history sheet was made by an Officer who said that, during the teatime patrol; the man had pressed his cell bell numerous times, often making bizarre statements. He appeared to the officer to be unaware of where he was and what he was doing.

83. The regular landing officer returned to duty on the wing on the morning of 6 January. The first entry in the man's history sheet that day was made by an Officer at 7.40 am. In interview, the regular landing officer explained that prisoners collect their medication first thing in the morning before breakfast is served. The Officer's entry reads:

> "Unlocked the man and told him to go down to the two's for his treatment. He kept repeating "You are releasing me? I don't believe it!" I tried to get him to go for his treatment but he kept talking and making no sense at all. He appears to be very mixed up and confused."

84. The regular landing officer had read the history sheet and wing observation book and was aware that entries about the man had continued in the same vein as the written remarks he made on the evening of 3 January. On 4 January,

85. The same officer who placed the man on report for possessing a line, wrote a Security Information Report (SIR). The SIR said that, when the officer was unlocking B wing at breakfast time on 4 January, various prisoners made veiled threats to harm the man due to his erratic behaviour during the previous night. According to the other prisoners, the man had banged his door and shouted out throughout the night.

86. In similar fashion, on the morning of 6 January a number of prisoners on B wing told the regular landing officer that they were 'sick' of the man 'ranting and raving' throughout the night. The regular landing officer wrote in the observation book and history sheet at 8.35 am of his fear that there might be repercussions. He also submitted a SIR about his fears but this SIR could not be traced while my investigators were at Holme House.

87. The regular landing officer explained that SIRs are sent to the prison's security department and are used to report any incident that a member of staff feels could have security implications. The regular landing officer's fear was that there would be an assault on the man by other prisoners. Five or six prisoners, all from the same landing as the man or the cells directly beneath him, went to the officer and said that he needed to get the man off the wing because he had kept them up all night.

88. The regular landing officer went to the Senior Officer (SO) with his concerns. The SO wrote in the observation book that he was confronted by numerous prisoners during breakfast. They complained about the man. The SO knew that the man was on report that morning. He said he would suggest at the morning meeting that "he remains in the segregation unit or be located in the hospital. He is clearly not fit for normal location." In the history sheet Tte SO made a second entry stating that he had spoken to the man and told him that his behaviour was not acceptable for normal location. The SO wrote that the man "needs to be assessed by a psychiatrist or that type of person, ASAP." The regular landing officer sat in during the meeting between the senior officer and the man. He was asked by my investigators how the man came across at that time. The regular landing officer's assessment was that the man did not seem to know where he was, "he thought we were going to release him, just bizarre, confused behaviour."

**The man’s mental health assessment on 6 January**

89. The regular landing officer and another officer escorted the man from Houseblock 3 to the segregation unit for his resumed adjudication. The regular landing officer and the Senior Officer had agreed that the regular landing officer should check with the mental health in-reach team (MHIT) that the man had been referred to them. The regular landing officer rang his colleagues in mental health from the houseblock phone. He then escorted the man to the segregation unit and immediately afterwards visited the mental health team in the healthcare centre.

90. The regular landing officer confirmed he was aware that any member of staff at Holme House who is concerned about any prisoner can complete a mental health referral form.

91. There are two Registered Mental Health Nurses (RMNs) working in Holme House. The first RMN remembered receiving a phone call from the regular landing officer just after 9.00 am on 6 January asking if she had received a referral for the man. She said she would check her records. When she did so, she established that a referral for the man had definitely not been received before that time. She recollected that the regular landing officer was adamant that he wanted to know if the man had been referred previously. Within about ten minutes, before she could ring the regular landing officer back on the houseblock, he appeared in her office. He told the nurse that he was extremely concerned about the man and that he was displaying bizarre behaviour. The first RMN told him that they had not received a referral form. She gave him a blank form and he sat down and filled it in immediately.

92. The regular landing officer wrote that the reason for referral was “needs to be assessed because of his continued bizarre/paranoid behaviour.” The next question asked him to indicate areas of concern, for example, unusual or bizarre behaviour, high risk of suicide or risk of self neglect. The regular landing officer described the man’s behaviour whilst located on Houseblock 3.

93. The two RMNs said in interview that they decided they would assess the man immediately in the segregation unit. Normal procedure at Holme House was that allocation meetings were held on Monday, Wednesday and Friday lunchtimes and new cases would be allocated, if appropriate, at those meetings. The two women decided that, given the circumstances and the level of concern that the regular landing officer was displaying, they did not wish to wait until the allocation meeting later that day with the danger that the man would not be seen until after the weekend. They went to the segregation unit and saw the man at 9.50 am, before his adjudication was resumed. The two nurses confirmed that the man had not been drawn to their attention either by healthcare colleagues or by any prison officers prior to the morning of 6 January.

94. During the assessment of the man, which took approximately an hour to complete, the first RMN asked most of the questions and the second RMN recorded the necessary information on a screening assessment document.

She wrote that the reason for referral was the man's bizarre behaviour on the houseblock. He said he believed he was going to be killed and was spending all night shouting from his cell and disturbing other prisoners. The man told the nurses that he had no previous contact with the mental health services. He said there was no family history of psychiatric problems. He told them he had been on a detoxification programme for his alcohol abuse since coming into custody. He said he was a heavy drinker, drinking two and a half bottles of cider a day and having his first drink when he got up in the morning.

95. The second RMN noted that the man was dressed in his prison clothes. She said he sat on the bed in his cell in the segregation unit and was quite relaxed. He maintained quite good eye contact with both nurses and his speech was fairly normal in weight and tone. There was no evidence of distress while he talked. There was no evidence of any depression or depressive type symptoms. Nor was there any evidence of pressure of speech or elation in his moods.

96. The man described some paranoid symptoms. He believed that people were out to kill him and said he knew this through hearing it on the prison tannoy system. The man stated he had met a gangster two months previously and, because he would not do as the gangster wanted, there was a contract out on him. The nurses asked the man if they could see him again in a week or two but he said he would be dead because the gangster would have killed him. The nurses thought he was quite frightened about all of this. At one point he told them that he had flooded his cell because he wanted people to come and help him.

97. The man described visual hallucinations and spoke of having seen women dancing on the walls outside his cell. My investigators asked the nurses about the man's tone of voice as he described these frightening hallucinations. They replied that the man remained relaxed throughout. His voice was not raised and he did not become distressed in any way.

98. The nurses asked the man about thoughts of suicide or harming himself. The second RMN said "he adamantly denied that he had any of those thoughts or any plans or anything like that. He also denied any history of having ever tried to harm himself or kill himself." He talked about having paper in his ears which he said "was to cut out the noise of the Irish singing which has been going on for three days." The nurses confirmed that the man took toilet roll paper out of his ears, showed it to them and then put it straight back in his ears again.

99. When talking about his family, the man said that his wife had died 20 years previously after 30 years of marriage. He said he had worked as a crane driver but had stopped when his wife died because he did not feel he could cope with working. He said his second son was a prison officer but he was not really sure where he lived. He thought it was in the Kent area.

100. The nurses wrote that the man's concentration seemed quite poor at times and he was confused about his current location because he had moved several times within the prison.

101. At the end of the document the nurses wrote a summary of their assessment. They referred to evidence of confusion and to auditory and visual hallucinations although they added that the presentation was inconsistent. They felt that the man needed further assessment. They agreed that they would refer him to see a psychiatrist as soon as possible. They expected that he would be seen by a visiting forensic psychiatrist, on the afternoon of the following Monday, 9 January 2006.

102. The last part of the action plan that the nurses agreed after seeing the man was that they should discuss with the prison medical officer whether he should be transferred to the healthcare centre. The first RMN explained that their joint view was that the number of moves which the man had already made might have contributed to his confusion and disorientation. They were unsure about whether he was suffering from psychosis or not and they felt the healthcare centre was the best place for him because there is usually a Registered Mental Nurse (RMN) on duty there. They had decided he should be assessed by the psychiatrist the following Monday and hoped that even more information would be obtained during the intervening weekend. The first RMN told my investigators that, by observing and communicating with a patient, staff hoped to obtain "a much bigger, clearer picture."

103. In interview, the first RMN explained that she was a gateway worker at Holme House, which was a role entirely new to the Prison Service. A pilot scheme had been introduced at Holme House on 30 August 2005, just over four months before the man's death. The first RMN explained that normal practice in the community is for a gateway worker to be based within a GP practice. If a GP saw a patient who was displaying any mental health problems he or she would refer the patient to the gateway service. The gateway worker sees the patient and might then take that person onto their own caseload or refer the patient to the most relevant service. They were concerned that the man had not been drawn to their attention before 6 January, either by healthcare colleagues or by any prison officers.

104. In interview, the first RMN emphasised that referrals to the mental health team can be made by anyone at all. They can be made by healthcare professionals or prison staff or may even take the form of self referrals. The first RMN said that the people they see may not have been previously known by psychiatric services and they did not have to be on a care programme approach (CPA) in the outside community. There was no indication, for example, that the man had had any previous contact with community psychiatric services.

105. The first RMN told my investigators that there were 17 referrals to mental health services in the three months before the pilot programme began. In the first three months of the new programme, there had been an 11 fold increase in the number of referrals to 186. The first RMN was eager to deliver mental health training at Holme House and had already done so at HMP Durham.

My investigators asked her what sort of education was required and she replied:

> "Right across the board, through healthcare, the officers, probation [need to know] about what is mental health, what is mental illness, what's an appropriate referral, what isn't an appropriate referral … there is a big need to drive that forward."

106. The nurses in the mental health team told my investigators that they wanted the man to be observed in the healthcare centre during the weekend after they had assessed him on 6 January. They said that they never worked in the inpatient part of the healthcare centre and that they did not attend handover meetings between shifts of nurses in the healthcare centre.

107. After the man had been seen by the RMNs, the Governor completed the adjudication started by one of his colleagues the previous day. The man pleaded guilty to the charge against him and told the Governor that he had made the line by tearing his bed sheets. When asked for what purpose, he replied that it was to try and get some food. The punishment selected by the Governor was a caution, the lowest possible punishment he could administer. There is no indication at section 4 of the initial record of hearing that the question of the man's fitness for adjudication was formally considered on either 5 or 6 January.

108. A lengthy but untimed entry was made in the clinical record on 6 January by the Doctor. The previous entry in the record is timed at 1.50 pm and was made by the second RMN so my assumption is that the doctor's entry was made some time during the afternoon of 6 January. The entry states that the doctor saw the man in the segregation unit after he had caused disruption on the houseblock again. Erratic behaviour was observed and the man kept making reference to "the Gangster", who wanted to kill him. He said he felt as though the gangster would come into the prison to kill him. He also spoke of hearing music and seeing women dancing. The doctor recorded that the man was currently orientated to time, person and place. He recorded that the man should remain in the healthcare centre over the weekend and be seen by the other doctor on Monday 9 January.

109. The prison's computer record on the Inmate Information System (IIS) shows that the man was located in cell HA1-5 for the fourth and last time at 12.03 pm on the afternoon of 6 January. The man remained in that cell until his death the following morning.

**The night and early morning of 6 and 7 January**

110. There are no recorded entries documenting the man's behaviour during the afternoon and early evening of 6 January. During the night, two members of staff were on duty in the healthcare centre. They were an RMN and an OSG.

111. The OSG recalled that on the night of 6 January the man's behaviour was not as challenging as it had been previously. He was, however, still walking up and down, shouting out of the window because he thought someone was drilling in the cell next door to him.

112. The RMN made an entry in the man's clinical record at 11.15 pm. She wrote that he had flooded his cell using a cup to pour water over himself. She went to his cell and asked him to stop throwing water over himself as he was flooding the cell. She said he swore at her and told her that he was cooling himself down. She phoned the night orderly officer and asked him to turn the man's water supply off. The man was in a cell with camera cover and the nurse noted that, while he was being observed on camera, the man began to use his dirty clothing to dry the water up. She noted that "he then tried to obtain water from the toilet and seemed to be examining this for some time. Observation maintained."

113. The RMN recalled that the night orderly officer, an SO came at about midnight to turn off the water supply. The OSG remembered that at the time the man had put his jumper on the radiator so that it would not get wet. He was standing at the sink in his boxer shorts pouring cups and cups of water over himself. Once the water had been turned off the man still did not settle down. The OSG said he spent some time kicking the water around his cell but then began cleaning the walls

> "which he often did, after he'd done something in his cell, in the morning it would be spick and span again, there'd be no water on the floor anyway. He mopped up the water using his clothes."

114. The man was in a camera cell but he was not on an open Assessment, Care in Custody and Teamwork document (ACCT - the Prison Service system of monitoring and supporting prisoners thought to be at risk of suicide or self harm) because he was not perceived as being at risk of self harm. The RMN told my investigators there were two men on ACCT documents during the night and this meant they were subject to enhanced observations, requiring staff to attend their cell and physically interact with them. As far as the man was concerned she had been given no instructions, either on the board in the nurse's office or in the handover book, about how frequently he was to be observed during the night. The nurse's office, where the two women were based, was in a corridor at right angles to the cells where the man and other inpatients were held so they could not see directly into his cell from the office. The cameras in the man's cell, and those containing the men on enhanced observation, were supposed to transmit pictures to the monitor screen in the nurse's office but both women drew attention to the fact that the quality of the CCTV system was poor and sometimes it failed completely.

115. In interview, the RMN said that the man took some time to settle after his water was turned off. She looked through the hatch in his cell door to begin with and then she and the OSG watched his behaviour on the camera screen. Her memory was that between 1.30 and 1.45 am he was lying on the base of his bed. He had thrown his mattress onto the floor earlier in the morning. My investigators asked the RMN if it was easy or difficult at this time to see what the man was doing inside the cell. She replied that it was easy to see what was going on when he was actively doing things. She said that when he was lying on his bed it was not possible to identify by looking at the screen whether he was breathing or not.

116. The two women first became aware that something was seriously wrong with the man at almost exactly 5.00 am. In her statement to the Governor, the OSG wrote that, at 5.00 am, she was changing the monitors for the camera cells because she could not get a clear picture when HA1-5 came onto the big television. She noticed that the man was "a funny colour". In her interview the RMN explained that

> "because there was a bit of camera failure she [the OSG] was trying to get the imaging right because of the men they had on observations."

117. Unusually, a large colour picture of the man's cell came up on the screen, compared to the poor quality black and white split screen images on which they normally had to rely. Both women agreed that the man did not look well so the RMN went to the man's cell. She looked through the observation panel then shouted to OSG to get help. The RMN ran to the clinic room to fetch the emergency bag.

118. The OSG went towards the man's cell, calling on her radio for Oscar 1. (Oscar 1 is the radio call sign for the night orderly officer.) He and his assist, were about to leave their office in order to remove the double locks which provide additional security in a prison during the night time period. Their office is adjacent to the healthcare centre and therefore the two men arrived at the man's cell within seconds of the alarm being raised. The night orderly manager arrived so quickly that he used his own cell key to unlock the man's cell before the OSG was able to break the sealed packet in which she carried a cell key for emergency use.

119. The assist said in his statement that, when he and the night orderly manager entered the cell, they observed the man lying on his right side with a sweatshirt forming a ligature tied to the top of his bedstead. The assist took the ligature knife that the OSG was carrying and, assisted by the night orderly manager, cut the ligature around the man's neck. The OSG had asked for an ambulance over the radio at the same time as she summoned Oscar 1. She recalled that the radio signal was not very good and, because she feared that the control room might not have received her message, she ran to a telephone to double check that an ambulance had been summoned.

120. The log kept by the control room at Holme House records the first radio message at 5.05 am. At that time, call sign Hotel 1 (a healthcare centre call sign) asked for Oscar 1 to attend the hospital immediately because there was a ‘code blue’. (Code blue is a signal that a prisoner is hanging.) The next entry in the control room log was at 5.06 am and recorded a request from Hotel 1 for an ambulance. Two entries at 5.07 am indicate that an ambulance was en route to the prison and that the prisoner in the cell was the man. At 5.17 am, the ambulance arrived at the prison and the crew made their way to the healthcare centre.

121. At interview the OSG described the man when staff first went into his cell:

> “The man was lying on the bed and the bed didn’t have a mattress on. He was lying on his right-hand side with his shoulders raised up so you couldn’t actually see his head, just the bulk of his body. His arms were down by his side and he was like in the foetal position like he was lying.”

122. The assist explained in interview that he had worked at Holme House for 13 years. For his first two years he was a nurse employed in the healthcare centre. For the next nine years he worked as a healthcare officer then, for the two years prior to the man’s death, he worked in the therapeutic community located on Houseblock 5. The assist qualified as a Registered General Nurse at Hartlepool in 1988. At the time of the man’s death, he retained his professional nursing registration although he was then working as a prison officer. When the assist, the night orderly manager and the RMN first entered the cell the floor was wet. The assist went to the mattress store directly across the corridor from the man’s cell and brought back a brand new mattress. He put it down on the cell floor then he and his two colleagues lifted the man onto the mattress. He said he felt for a pulse but could not find one. He said that the man was obviously not breathing. The emergency equipment that the RMN had brought to the cell earlier included an oxygen cylinder and an Ambu-bag (the brand name of a bag which is placed over a patient’s face and used to administer oxygen).

123. Once the man had been placed on the new mattress, the night orderly manager said he realised immediately that he had blocked his airways with putty. The night orderly manager said that the man had made some sort of putty out of toilet roll and water and had then pushed it very hard up both nostrils. The night orderly manager realised that staff would not get an airway until the putty had been removed. He managed to do this although it was quite deep in the man’s nostrils. Once the putty was removed the staff got him into a position where they could tilt the man’s head back and open his airway. The night orderly manager recalled that the assist started to give the man oxygen with the bag. Almost immediately, he swapped with the RMN who took over on the bag while the assist attempted cardio pulmonary resuscitation (CPR).

124. The assist estimated that they carried on trying to resuscitate the man for ten to 15 minutes until the ambulance crew arrived. The RMN was trained in first

aid at the time of the man’s death and, although the assist ’s first aid qualification had expired, he said that he had administered CPR many times in hospital and had also done it in the street a couple of times.  My investigators asked the assist if he was offered any relief once he had started working on the chest compressions along with Nurse Fortune.  The assist replied that he and the nurse had got into a good working rhythm so that, although the night orderly manager offered to take over the bagging, they were able to keep going without a break until the paramedics arrived.

125. The control room log has an entry at 5.25 am recording information from the night orderly manager that the man had died.  The RMN recalls that when the two paramedics arrived they entered the man’s cell and attached defibrillation pads to him.  They said that there was nothing else that could be done and at that point efforts to revive the man ceased.  The assist was of the opinion that the man was probably already dead at the time when prison staff first entered his cell just after 5.00 am.  The ambulance was escorted from the main prison gate to the healthcare centre by an Officer.  Both the night orderly manager and the officer had the foresight to unlock gates through which the ambulance would have to pass in order to make a quick passage to the healthcare centre.

126. The control room log indicates that a doctor was informed of the man’s death at 5.48 am.  The same log shows that he arrived at the prison at 6.17 am. The doctor is a partner in a general medical practice in Middlesbrough and he has also been a part-time medical officer at Holme House since 1992.  He saw no signs of life in the man and pronounced him dead at 6.35 am.

127. A post-mortem was conducted later on the morning of 7 January by one of the Home Office pathologists for the North East of England.  In the summary and conclusions section of his report to the Coroner, the pathologist wrote that:

> “The post-mortem examination has shown that the deceased had significant enlargement of the heart and significant coronary artery disease such that it could have brought about death at any time. Although this condition could have accelerated death during an asphyxial process due to pre-disposition of a fatal arrhythmia, there is no indication that it did so in this case.”

128. In the pathologist’s opinion, death was due to hanging and he added that the mode of death was asphyxia, brought about by pressure to the neck as a result of a ligature.

**Contact with the man’s family**

(i) Contact between Holme House and the man’s partner

129. When the man arrived at Holme House on 16 December, he was asked a number of personal questions which were recorded on the personal summary sheet of his core prison record. He indicated at that time that he had been living at an address in Hartlepool and that his partner lived at the same address. On 16 December, the man had indicated that the person to be notified in an emergency was his partner. No additional information had been recorded about the man’s next of kin or other people who should be contacted in an emergency.

130. During the weekend of 7 and 8 January, there were two Governor grades on duty. The first Governor was in charge of the prison during the weekend and the second Governor was the duty Governor on 7 January. The acting Governor of the prison was a third Governor. She was not scheduled to be on duty that weekend but came into the prison later in the morning in response to the man’s death.

131. Holme House had two trained Family Liaison Officers but neither officer was on duty during the weekend. The third Governor told the first Governor that, if necessary, she would go to Hartlepool herself in order to break the news of the man’s death to his partner. The first Governor managed to make contact with a Principal Officer (PO) who was one of the FLOs. Although it was his rest day, the FLO offered to come into the prison in order to see the man’s family. The FLO duly attended the prison during the morning. In accordance with the prison’s protocol with Cleveland Police, the FLO made arrangements that he and the Governor would be escorted to the home address of the man’s partner by the local police in Hartlepool. To their surprise it was clear to them when they arrived at the man’s partner’s home that she and her family were already aware of the death. It appeared they had found out from a friend of the man’s victim. The third Governor was extremely concerned to hear this and asked the Assistant Chief Constable of Cleveland Police, to make some enquiries.

132. On 19 January, The Assistant Chief Constable telephoned the third Governor with the results of his enquiries. Apparently the telephone call from the prison to Hartlepool police requesting an escort to the family home was taken by an officer who had been involved in the man’s case. This officer told the victim of the offence. He visited the victim’s flat, where it seems that a relative of the man was also present. This relative then informed the man’s partner’s family. The Assistant Chief Constable was most apologetic to the third Governor about this train of events. He informed her that the officer concerned had been advised about his actions, as had the officer’s superiors, and that a senior police officer would be visiting the family to apologise formally.

(ii) Contact between Holme House and the man's son

133. On Tuesday 10 January 2006, three days after his father's death, the man's son wrote to the Director General of the Prison Service. He said that he wished to lodge a formal complaint against the first Governor of HMP Holme House. On 13 January, the Director General forwarded a copy of the man's letter to me, explaining in his covering letter to the man that I normally deal with the way in which contact with relatives after a death is handled.

134. In his letter of 10 January, the man explained that he had received a telephone call on 17 December from an aunt in which she informed him that his father had been found guilty of rape and sentenced to eight years in prison. The man said he made vigorous efforts to establish whether the information was true and to locate his father. He made telephone calls to Holme House but the phone was never answered. On 18 December, he contacted the Prisoner Location Service and gave them a number of factual details about his father. On 21 December, he received a reply stating that they could trace no one in the prison system with those details.

135. By 7 January 2006, the man's son had still not received formal confirmation about his father's status or where he was being held. At approximately 3.45 pm on the afternoon of 7 January, the man's aunt rang again and broke the news that his father had taken his own life at Holme House.

136. The man's son was himself a Senior Officer at a prison near London, although he was not working at the time of his father's death. He immediately rang Holme House and asked to speak to the orderly officer about the death of the man. At Holme House, the orderly officer is a Principal Officer (PO) whose task is to ensure the smooth daily running of the prison and to respond to incidents and emergencies. The orderly officer asked for the man's phone number so that the duty Governor could call him back.

137. According to the man's letter to the Director General, the first Governor called back approximately five minutes later. The first Governor told the man's son that there was no mention of him as next of kin. This upset the man's son but he accepted that his father might not have put him down as next of kin because of the sensitivity of the man's son's occupation. The man's son asked the first Governor what Holme House was going to do with the body but the first Governor would not say. The man's son said he put down the telephone until he had gathered his thoughts. The man's son alleged that the first Governor did not treat him with decency and respect and further alleged that the first Governor discriminated against him "because he understood himself to be speaking to the son of a rapist." During the rest of the weekend the man's son received no contact from anyone in the Prison Service.

138. The man also wrote that, at 10.00 am on Monday 9 January, he telephoned the Governor's secretary at Holme House asking that someone inform him of the location of his father's body. Approximately five minutes later, the first Governor phoned him. There was some discussion between the two men as to whether their previous conversation had been on the Saturday or Sunday

of the weekend. The first Governor allegedly told the man's son that he did not like his attitude and the man's son in turn said that he did not like the first Governor's "because he demonstrated no respect for me, for my situation or my father's death. I put the phone down."

139. Immediately afterwards, the man's son again rang the Governor's secretary who put him through to the third Governor. (As noted, at the time of the man's death the third Governor was the acting Governor at Holme House.) The third Governor spoke to the man in a manner he described as clear, calm and courteous. He felt she demonstrated understanding of his very difficult and traumatic situation. She offered him the services of a Family Liaison Officer but the man declined the offer as his home is so far away from Holme House.

140. The third Governor herself carried out an investigation into the complaints made by the man's son to the Director General. For the purposes of her inquiry, the third Governor interviewed the first Governor, the second Governor and the orderly officer on the afternoon of the man's death. I am very grateful to the third Governor for making all the relevant papers available to me. At the close of her enquiry, the third Governor made two recommendations. The first was:

> "The first Governor has been advised that his comment "I don't care for your attitude" was inappropriate. He has accepted that advice. I do not recommend any further action in relation to this."

141. The third Governor also recommended that the man should receive a further letter of apology from the new Governor. The new Governor wrote a detailed letter of apology to the man's son on 14 February, with copies going to the Director General and the Prison Service's North East Area Manager.

142. I am pleased that the Prison Service mounted its own investigation so rapidly into the complaints made by the man's son. I have, of course, made my own independent enquiries into the serious issues raised by the man's son. As The Director General said in his immediate response, I pay very close attention to the way in which contact with relatives is handled in the immediate aftermath of a death in prison. At the beginning of February, two of my colleagues, an investigator and an FLO, visited the man's son and his wife in their home near London where the man's son explained the matters that were troubling him. He asked my colleagues why no one from Holme House had called him back after his initial conversation with the first Governor on the afternoon of 7 January. He also asked why he had to wait until Monday 9 January before someone from the prison where he was employed came to speak to him. My investigators then carried out lengthy interviews with both the first Governor and the Head of Residence at the prison where the man's son worked, in order to establish what had taken place in the first 72 hours after the man's death.

143. On 9 January, the first Governor wrote a memorandum to the third Governor detailing his contacts with the man's son. In his memo, he explained that he was given a telephone number by a PO. After his briefing from the PO, the

first Governor said he reassessed the information available in the man's core record. He said he discovered, in a report completed by the mental health in-reach team, a reference to a son of the man possibly living in the Kent area and employed within the Prison Service.

144. The first Governor then rang the man's son and endeavoured to explain to him that he needed to verify his identity before he could release any details about the death that morning. According to the first Governor, the man's son put the phone down before he could establish any facts.

145. In an effort to ascertain if the man's son was the son of the man who had died, the first Governor compared the telephone number given to him by the PO against the list of people sharing the man's surname in the Prison Service's computerised staff directory and established "a tenuous link" to a prison near London. He contacted the duty Governor at that prison and she confirmed the telephone number as that of the man's son who was currently employed there. The first Governor requested that a manager make contact with the man's son to inform him of the situation.

146. The first Governor confirmed that he had telephoned the man's son a second time on the morning of 9 January after the man's son contacted the Governor's secretary at Holme House. The first Governor wrote that he endeavoured to calm the man's son and to engage in meaningful dialogue but the man's son terminated the call.

147. At the time of the man's death, the first Governor was the Head of Security at Holme House. In interview, he emphasised that he did not wish to release confidential information to a person about whose identity he was not certain. The possibility that the man might have a son who was a serving prison officer was first discovered on 7 January by the third Governor, not by the first Governor or the second Governor. At the time, the two men were dealing with the many actions that had to be taken after the man's death and they also had to maintain safety, order and activity in a large local prison. The first Governor chaired a debrief around 9.00 am for staff who had been intimately involved in responding to the emergency and he then conducted adjudications on prisoners who had allegedly broken prison rules. The Governor went to Hartlepool with The FLO to break the news of the man's death to his family. When the third Governor arrived at the prison later in the morning she had time to study the man's prison record carefully and it was she who noticed the reference to as son in the notes of the mental health assessment conducted the previous day by the two RMNs. She was not able to alert the first Governor directly to this information as he was conducting adjudications at the time. The first Governor felt that, even if he had received the information about the man's son's occupation before talking to him, he would still have wished to establish very carefully who the man's son was. The first Governor said "my fear was just willy nilly give information to somebody then what are they going to use that information to do and then I could be accused of giving confidential information about a prisoner to some stranger."

148. My investigator asked the first Governor about the length of the first conversation with the man's son and he estimated it was a minute or a minute and a half. The first Governor said that the man's son slammed the phone down on him and he vehemently refuted the man's contention that he had been treated inhumanely and unfairly.

149. The first Governor then rang his colleague at the prison near London to ask if a Senior Officer who was the man's son was employed there. The first Governor was concerned that the man's son was under duress and asked his colleague if it would be possible for somebody to visit the man's son at his home address and explain the situation to him. (The man's son and his wife lived close to the prison where he was employed.) The first Governor said in interview that his colleague "assured me that she would endeavour to have somebody visit if not that day certainly in the next two days."

150. My investigator put it to the first Governor that this seemed a rather leisurely response to the absolutely critical information he was giving. In reply the first Governor said that he did not know whether the man who worked at the prison near London was indeed the son of the man who had died at Holme House and what he wanted to happen was:

> "I wanted them to go round and establish by speaking to the individual directly, is the man the deceased's son, and then explain the situation to him."

151. The first Governor was asked what he was going to do next after the conversation with his colleague and he replied:

> "I left the circumstances as they were, on the understanding that [the prison near London] would come back to me, they still hadn't confirmed that there was a son for the man."

152. The first Governor agreed with my investigator that the telephone call between himself and the man's son had ended rather abruptly but said he had not given any thought on the Saturday afternoon to the possibility of someone else making an attempt to re-establish contact.

153. The first Governor estimated that his second telephone call with the man's son, on the morning of 9 January, lasted no longer than the first. He thought the two men had spoken for 30 seconds or a minute at most. The first Governor recollected that the second conversation moved almost immediately from a calm level to again becoming rather irate. He said he was trying to assist the man's son but admitted he had said that he did not like the man's son's attitude. He said he had not chosen the expression vindictively and "it wasn't said with any malice, or any intent or any view to cause any damage to any individuals or distress."

154. My investigators asked the first Governor if he or other senior managers at Holme House had given any thought between the late afternoon of 7 January and the morning of 9 January to the possibility of making renewed contact

with the man's son. The first Governor replied that he was awaiting information from the other prison because, he said, "I hadn't established at that stage whether the man's son was the son of the man."

155. My investigator went to the prison where the man's son worked in order to interview the Governor. In interview, the Governor confirmed that she received a phone call from the first Governor at Holme House at approximately 5.00 pm on the afternoon of 7 January. It was the end of her duty period and she was in the communications room collating the roll before going home. When the first Governor unexpectedly telephoned her at that time, she confirmed that the telephone number he had been given by the man was the home telephone number for the man's son who worked at her prison. The Governor said that the first Governor asked if she could arrange for someone to speak to the man's son to assist in confirming his relationship with the deceased man. She "advised that I would do that but it wouldn't happen until Monday 9 January."

156. My investigator asked the Governor why it would not be possible for somebody to speak to the man's son before Monday 9 January. She replied that the man's son's line manager was not on duty during the weekend and she "thought it was appropriate that whoever went round was a line manager and was in a position to be able to deal with this matter sensitively."

157. The Governor added that she was conscious the man's son had already spoken to the first Governor and "if indeed it was his father then he [the man's son] was obviously aware of what had actually happened."

158. My investigator asked if any thought was given to someone other then the man's son's immediate line manager going to see him during the weekend. The Governor replied that the man's son was obviously aware of the man's death at Holme House and she "didn't believe that he would want to know that we [senior management at his place of employment] were involved in this in any way really at that time."

159. On the morning of Monday 9 January the man's son's immediate line manager, returned to duty after his weekend off. He was instructed by the Governor to visit the man's son at his home address and duly did so. At this point it was finally established that the man's son was the man's son and he was formally told of his father's death in Holme House on Saturday 7 January.

## Consideration and Conclusions

(i) The man's medical care while at Holme House

160. At my request a clinical governance lead for North Tees PCT, undertook a clinical review and wrote a detailed medical report. The first three and a half pages of the clinical reviewer's report set out a day by day chronology of what the man did and what happened to him. It is very striking in the chronology to see the numerous references to the man smashing all his furniture, continuing to shout, scream and bang, flooding his cell, appearing confused and complaining of hallucinations, being agitated and confrontational, being noisy and disruptive or presenting "bizarre" and "paranoid" behaviour.

161. In the discussion section of his document, the clinical reviewer writes that the man was rightly placed in the healthcare unit when he arrived at the prison on 16 December. The following day he was diagnosed as having alcohol withdrawal syndrome and was correctly, according to the clinical reviewer, placed on a detoxification regime which was to last about ten days. The clinical reviewer writes that, from 18 December, the records show that the man exhibited "unusual" and sometimes "bizarre" behaviour. The clinical reviewer :

> "Finds it difficult to understand why more medication was not offered when the notes record shouting, screaming, confusion, disorientation, hallucinations and violent behaviour when the man smashed a table in his cell during the period 18.12.05 – 27.12.05."

162. The clinical reviewer discusses the contact with the man's GP on 29 December 2005 and notes the GP's comment that bizarre behaviour was "normal behaviour for the man to use any means to manipulate to get what he wants." The clinical reviewer's assessment of the telephone conversation with the man's GP is that, while it provided good background information, it did not preclude the attending doctor from forming an assessment of the patient in his care. The clinical reviewer's discussion continues:

> "If the doctor was concerned, why did he not arrange a mental health assessment of the patient to address his concerns? It appears that too much reliance was given to the GP's opinion of the man's past behaviour rather than assessing the patient's presenting behaviour and condition at the time."

163. The clinical reviewer expresses surprise about two decisions on 3 January 2006 when the man was both considered fit for adjudication and referred for an assessment by the dementia team. The clinical reviewer writes:

> "This decision seems unusual, when the prisoner is deemed to be fit to understand adjudication but is in need of a possible dementia referral, which may mean that he would find it difficult to understand an adjudication process."

164. The clinical reviewer notes that the man was assessed by the community mental health team on 6 January, when the nurses decided that he should be urgently assessed by a psychiatrist at the beginning of the following week. The clinical reviewer wonders why no further medication was offered to the man at that time in order to deal with his “bizarre/paranoid behaviour.”

165. At the end of his report the clinical reviewer makes three recommendations. These are:

    1. **I feel that it is good practice on reception to the prison to contact the prisoner’s GP to get a full past medical history and a list of their current and past medication.**

    2. **Patients who show signs of hallucinations and paranoid ideation should be offered urgent assessment of their mental state and be given medication in the interim to deal with their presenting behaviour.**

    3. **Not all entries in the record had a time and name attached. I feel that doing so should be standard practice.**

**I endorse all three recommendations made by the clinical reviewer.**

167. I note that his first recommendation corresponds closely with instructions contained in Prison Service Order (PSO) 3050 on the continuity of healthcare for prisoners which was issued a month after the man’s death.

168. A copy of the clinical reviewer’s clinical review was made available to the locum medical officer. On 6 June, the locum medical officer wrote to my investigator and said there was no evidence of mental disturbance when he saw the man on 17 December. The locum medical officer saw the man again on the afternoon of 17 December when the man volunteered information to the doctor that he drank quite excessively. The doctor assessed him as suffering from alcohol withdrawal syndrome and started him on treatment with chlordiazepoxide. The locum medical officer reviewed the man in the hospital wing on the morning of 18 December. The locum medical officer did not see the man again for two weeks until 3 January 2006. On that date, based on the information that had been received from the man’s GP and his presentation that day, the doctor felt he was fit for adjudication. After a general discussion between the doctor and nurses a referral to a dementia team was made by one of the nurses.

169. On 6 January, the locum medical officer saw the man for the last time following his assessment by the second RMN. The doctor and the second RMN agreed that it would be best to locate the man in the hospital wing until he had been fully assessed by a psychiatrist. The locum medical officer felt at the time he should wait for a full assessment and recommendation by the psychiatrist before starting on any treatment.

170. I am extremely concerned that the man was not brought to the attention of the mental health team until the day before his death. The clinical reviewer's medical report strongly suggests that the man's mental health should have been assessed at an early stage. The delay would appear to suggest that the identification and referral of prisoners who need, or may need, to be seen by mental health staff at Holme House may not be happening as quickly or smoothly as it should be.

171. The system at Holme House provides that any member of staff is able to complete a referral to the mental health team using the gateway process. The man consistently displayed extremely disturbed and confused behaviour during his three weeks in prison. Indeed, several staff made entries on various documents testifying to the bizarre nature of his behaviour. Despite this and the open access nature of the referral system, no member of staff saw fit to refer the man to the mental health team until the regular landing officer commendably did so on 6 January. There may have been an opportunity to obtain a deeper understanding of the man's bizarre behaviour on 29 December 2005, when the clinical nurse manager telephoned the man's GP in Hartlepool. I share the clinical reviewer's concern that too much reliance was placed on the GP's opinion that the man could be manipulative. An entry in his medical notes translated this opinion into an assumption that txamination of his disturbing behaviour.

172. I note too that RMNs do not attend the handover meetings with staff who work directly with the inpatients in the healthcare centre. It appears to me that their attendance at such meetings may help to identify prisoners with mental health needs.

**I recommend that urgent management attention should be paid by the Governor, healthcare manager, Primary Care Trust and local Mental Health Trust to the integration of the expanded mental health team at Holme House within existing clinical services so that the best possible value (both clinical and financial) is obtained from their skills and expertise.**

**Staff in the mental health team have enormous and critical skills to place at the prison's disposal. I recommend that the Governor makes use of the readily available talent within the mental health team to deliver a programme of training on mental health issues to selected staff as soon as possible.**

(ii) Training for healthcare staff

173. A point of good practice at Holme House is that all nurses have been trained in first aid. However the nurse on duty during the night of 6 to 7 January when the man died told me that she had not been trained to use a defibrillator. In this case I do not think that the man's chances of survival were adversely affected by the fact that the RMN had not received defibrillator training. However, the nurse on night duty at Holme House is the first line medical response for nearly one thousand prisoners. It is clearly essential that such a critical member of staff should receive training in equipment that may help to save a life.

**I recommend to the Governor and PCT that a programme of defibrillator training for staff in the healthcare centre should be introduced without delay.**

(iii) Camera cells in the healthcare centre

174. When my investigators first went to Holme House in January 2006, a number of staff expressed anger and frustration about the poor quality of the close circuit television (CCTV) system in the healthcare centre. The night orderly officer on the night when the man died said that the quality of the pictures on the monitor screen in the nurses' office was often "deplorable." My investigators examined the CCTV pictures and agreed that it was extremely difficult to make out any detail on the screens. There are a number of cells in the inpatient part of the healthcare centre with camera cover and pictures from these cells are beamed to the monitor screen in the nurses' office. The prison's policy statement for the temporary use of safer cells and camera cells was written in March 2005 and reviewed in November 2005. According to the policy statement, the aim of these cells is "to provide a safe and secure environment for those individuals deemed to be at high risk of suicide or self harm."

175. At the time of his death, the man was not thought to be at risk of suicide or self harm but he was located in cell 5 on the inpatient unit which did have a camera. My investigators were told that cell number 2, which was theoretically to be used for prisoners at risk of suicide, provided such low picture quality that it was akin to "looking into a sauna." The pictures from cell 2 were indeed of abysmal quality when my investigators saw them on the monitor in the nurses' office in January 2006. When my investigators returned to Holme House in April 2006 they discovered that thousands of pounds had been spent on the supply and installation of a digital recorder and flat screen monitors in the healthcare centre. Regrettably, the quality of picture being fed from cell number 2 to the monitor was still completely unacceptable.

176. There is no point whatsoever in having camera cells if the quality of the pictures from these cells is so poor that staff cannot actually see what is going on inside them.

**I recommend that the Governor ensures the CCTV equipment in the healthcare centre is fit for purpose and that staff have been adequately trained in how to use it.**

177. The policy statement of March 2005 is rather confusing. It says that safer cells or ligature free rooms are used as a last resort when the individual has been deemed at high risk of suicide, self harm or harm to others. The fifth key principle in the policy statement is that any person placed in these safer rooms will be on camera observation and a sixth key principle is that staff on duty will observe the individual at frequent irregular intervals and during this time allow the individual to ventilate their feelings. The policy statement does not say whether staff observation is direct observation at the cell door or observation on the monitor in the nurses' office. The staff on duty in the

healthcare centre at the time of the man's death did not think he was subject to frequent irregular observation, and it is difficult to establish from the policy statement whether the arrangements for prisoners liable to cause harm to others are exactly the same as for prisoners at risk of suicide or self harm.

**I recommend that the policy statement be reviewed, especially if the intention at Holme House is to continue locating prisoners at risk of harm to others in camera cells.**

(iv) Medical Fitting for Adjudications

178. I was surprised to see that the records of the two adjudications the man attended on 2 and 5 January 2006 contain no reference to his fitness for adjudication. The fourth section of the record of hearing contains a space for any relevant medical or psychiatric observations, including an opinion on the prisoner's mental condition at the time of the alleged offence. That section of the document is blank in both cases. This is especially surprising for charge number 0001/06 in view of the nature and location of the alleged offence. The man was charged with intentionally endangering the health and safety of himself and others by flooding, urinating and defecating in his cell in the healthcare centre on New Year's Day. Before the adjudication took place, the man had spent a number of hours in the special cell in the segregation unit, in itself an unusual and noteworthy occurrence.

179. My investigators obtained guidance on medical fitting for adjudication from the policy lead in the Offender Policy and Rights Unit at the National Offender Management Service in London. The policy lead referred to policy guidance issued in November 2003 which said that "the final decision as to whether or not the accused is fit for the hearing rests with the adjudicator." These instructions remained in force until 23 January 2006, just a fortnight after the man's death, when the Prison Service published PSO 2000 "The Prison Discipline Manual – Adjudications."

180. The new PSO confirms that the final decision as to whether or not an accused is fit to face a disciplinary hearing rests with the adjudicator. The new PSO states at chapter 2.25 that "a list of all those appearing before the adjudicator must be passed to the healthcare unit in sufficient time to enable any relevant concerns about individual prisoners to be given to the adjudicator before the start of the prisoner's adjudication." My comments about medical fitting for adjudications are not made in a spirit of bureaucratic box ticking but because it is fundamental that due process is observed, especially when the prisoner attending the adjudication is vulnerable or may have significant health problems.

**I recommend that the Governor reviews arrangements at Holme House for ensuring that accused prisoners are fit to face disciplinary hearings.**

(v) The man's location in the special cell on 2 January

181. Policy on the circumstances in which special cells and mechanical restraints may be used in prison is set out in Prison Service Order (PSO) 1600 on the Use of Force. Chapter 4 of the PSO states that special accommodation may be used for the temporary confinement of a violent or refractory prisoner but only if its use is necessary in order to prevent the prisoner causing self injury, injuring another prisoner or staff, or damaging property or creating a disturbance. The prisoner must not be confined in special accommodation as a punishment and, as soon as the original justification for the use of the special accommodation has ceased, the prisoner must be moved from that accommodation. (I may say in passing that I think the use of the word 'refractory' is very old-fashioned. It is not a word most staff could define.)

182. Chapter 4.6 of the PSO states that no prisoner shall be placed in special accommodation except on the prior authority of the Governor in charge. If he or she cannot be contacted the decision may be taken by the officer for the time being in charge of the prison. The decision to use a special cell must be recorded at once on form 2323 and the form must be signed by the duty Governor or by the officer taking the decision. If the decision has been taken by a person other than the duty Governor, the matter must be referred to him or her for consideration at the earliest opportunity.

183. Chapter 4.8 of the Order states that where special accommodation has been used the prison doctor must be notified as soon as possible and must examine the prisoner as soon as practicable. Where the doctor is satisfied there are no clinical contra–indications, he or she must certify accordingly by signing and returning form 2323.

184. Chapter 4.12 of the Order deals with monitoring, and states that the use of special accommodation must be discontinued immediately it is no longer necessary. The Governor in charge must personally observe any prisoner who is confined in special accommodation at least twice in every 24 hours. A prison doctor must personally visit any prisoner who is confined in special accommodation at least twice in every 24 hour period.

185. I have examined form 2323 relating to the man in the light of the stringent safeguards set out in PSO 1600. The form does indeed appear to show that the necessary actions were taken. That said, I am concerned by the quality of the decision making. It seems to me that the man's behaviour was treated solely as a disciplinary matter to be managed punitively. In addition to his location in the special cell and segregation unit on 1 and 2 January, he was twice placed on report and appeared at adjudication and he was later threatened with transfer to the segregation unit because he had disturbed other prisoners on Houseblock 3. Yet the man was a 67 year old man who had not experienced prison before. He was undergoing detoxification from chronic alcohol abuse and was demonstrably unfit for location on a regular wing. I accept that he proved extremely challenging to manage. Nevertheless, I consider that the first and most appropriate action would have been to ensure he received a proper mental health assessment.

(vi) The prison's contact with the man's family

186. It is very unfortunate that, despite the efforts of staff at the prison to inform the family of the man's death promptly, they in fact heard from a friend of the man's victim. It has become clear that a police officer was responsible for 'leaking' the news of the man's death to his victim, and I attach no blame to staff at the prison for what could only have been an extremely upsetting way for the family to hear the sad news. Indeed, I consider that the prison's contact with the man's partner and her family was unusually good. I particularly commend the FLO for his devotion to duty on 7 January. He came into the prison although it was his weekend off so that he could give support and reliable information to the man's family in Hartlepool. During subsequent days the prison provided a great deal of practical support to the Hartlepool family. On 9 January, the FLO arranged for a taxi to collect the man's partner and her sisters so that they could come to the prison and see the cell where the man had died, go to the undertakers to view the man's body and then have a taxi home again. The prison agreed to meet the cost of the man's funeral and the FLO attended the Coroner's Court with two members of the family when the inquest on the man's death was opened and adjourned. The family in Hartlepool expressed appreciation for the humane treatment they received from the prison in the days following the man's death. My investigators met with the FLO and were impressed by the qualities of sensitivity and empathy that he clearly brings to his new role.

187. The story of the man's son's contact with the prison does not make such happy reading. I am strongly of the view that further contact with the man's son should have been made during the late afternoon or early evening of 7 January after he had terminated his first telephone conversation with the first Governor. The Governor of the London prison said that when the first Governor telephoned her "he wanted to know if we had the man's son working here as an officer and if the number he'd been given actually coincided with the man that had contacted him." The answer to both questions was very clearly in the affirmative. At this point, the first Governor should have accepted the man's son's word when he said the man who had died at Holme House was his father. In any event, I do not consider that staff at either prison placed sufficient urgency on the matter of establishing whether the man's son was related to the man.

188. It is not surprising that the man may not have behaved in a calm and composed fashion during his first telephone conversation with the first Governor. The man had just been told by his aunt that his father had taken his own life in prison, and I can only imagine the shock and grief this must bring. The first Governor and senior colleagues at the prison should have immediately considered strategies to re-establish contact. I consider that the onus was on Holme House to make contact with the man's son because it was in Holme House that his father had died.

189. If the relationship between the first Governor and the man's son was strained, then consideration should have been given to finding another member of staff at Holme House who would be able to deal promptly with the man's son's

questions. It seems that consideration of security unduly outweighed consideration of humanity in the response to the man's son during the first weekend after his father's death. It is a great shame that the FLOs were not made aware of the existence of the man's son on the day his father died.

190. The man's son was so angry after his two telephone conversations with the first Governor that he wrote immediately to the Director General of the Prison Service. I have uncovered no evidence that the first Governor treated the man's son inappropriately because of the nature of the crime his father had committed. I agree with the third Governor that he should not have told the man's son that he did not care for his attitude. The third Governor observes in her report that in ideal circumstances it would have been a Family Liaison Officer who made contact with the man's son. There is no doubt that the death of the man emphasises the crucial role that FLOs can and should play in establishing and maintaining contact with bereaved families.

191. The newly revised Prison Service Order on follow-up to deaths in custody became operational on 4 January, just three days before the man's death. Chapter 4 of the PSO deals with support for the family and contains a hyperlink to additional guidance on Family Liaison following a death in custody which is available on the Prison Service's intranet. The supplementary guidance indicates that the Prison Service has decided to follow a very broad definition of a family, as developed by the Metropolitan Police. In answer to the question 'who are the family?' the highlighted guidance responds:

> "The term "family" can include "chosen" as well as "biological" and can include: husbands, wives, partners, significant others, parents, siblings, children, guardians and others who have had a direct and close relationship with the deceased."

192. The guidance adds that every family is different and has its own dynamics. It notes that many modern families are split by divorce or separation and:

> "there may be several branches all with equal rights to information… The Family Liaison Officer should be prepared to deal with different sections of one family if necessary."

193. The supplementary guidance recommends at section 4.9 that the family should be informed face-to-face as soon as possible after the death. In the following paragraph the guidance given is as follows:

> "If the distance from the prison presents a problem, a dedicated Family Liaison Officer or chaplain based in the area nearest to the family home could inform the family face-to-face… this individual must give the family contact details at the establishment where the death occurred and the visit should be followed up by that establishment as soon as possible."

194. During my investigation I was heartened to discover how determined the Family Liaison Officers in the North East area are to provide an excellent service. The third Governor is the operational link to these FLOs and attended a meeting with them at Holme House in July 2005. At the meeting an important discussion took place about the possibility of having an "on call" trained FLO on duty at all times. The on call FLO would be an additional resource to all prisons in the North East. Those attending the meeting thought the best option was:

- Each establishment would try to contact their own trained FLO in the first instance when a death has taken place.
- If that person was not available, the on call FLO could be contacted to provide the initial service.
- This person would attend the establishment (where the death has occurred) and start/complete the risk assessment prior to delivering the death message.
- They would then be deployed with a senior manager from the establishment to deliver the death message to the next of kin, if establishment FLO was still not available.

195. In August 2005, the third Governor wrote to the then North East Area Manager, telling him of the clear enthusiasm and commitment of the trained FLOs in the North East, and asking for his approval of the suggestion that there should be an on call FLO who would carry a pager at all times.

196. The man's death clearly underlines the point that the death of a prisoner may occur at any time of the day or night and not necessarily when a FLO is available. Holme House had two trained FLOs at the time but that resource was not sufficient to cope with the complexity of the situation. The prison needs to be able to liaise almost simultaneously with family members in quite separate parts of the country. Some imaginative thinking had already been devoted to this very issue by the third Governor and her FLO colleagues in the North East. I commend them for their foresight.

**I recommend, as a matter of urgency, that the Governor and Area Manager review arrangements at Holme House and other North East prisons for timely liaison with family members in the immediate aftermath of a prison death.**

197. The man's son was visited by his line manager on 9 January 2006, two days after his father's death. It was Holme House's responsibility to ensure that news of the man's death was conveyed to his son but the prison near London where the man's son worked at the time should not have delayed contacting him for two days. The Prison Service's own guidance refers to the possibility of a dedicated FLO or chaplain based in the area nearest to the family home informing the family face to face but this sensible alternative was not adopted by the prison near London.

**The Governor at the prison where the man's son formerly worked should review arrangements at that prison for timely liaison with family members in the immediate aftermath of a prison death**.

(vii) Good practice and commendable staff behaviour

198. The response by night staff to the emergency discovered just after 5.00 am on 7 January was excellent. The Senior Officer and his assist were in the orderly office adjacent to the healthcare centre when the alarm was first raised. They arrived at the man's cell just a few seconds later and immediately entered it. The four members of staff who were then present, the two men, the RMN and the OSG worked as an effective and disciplined team. The night orderly manager ensured that the blockages to the man's airway were removed and that staff were despatched to unlock gates which would have hindered the swift arrival of an ambulance. The assist and the RMN administered CPR to the man but regrettably their valiant efforts to revive him were to no avail. The OSG made sure that an ambulance was swiftly summoned and she had the presence of mind to make a telephone call to the control room in case her initial radio message had not been safely received.

199. The OSG had already had a great deal of contact with the man during her week of nights that began on 19 December. The man was evidently in great distress that week and there is evidence that she tried to reassure him and help him come to terms with a situation and location that was completely alien to him.

200. Another notable contribution was made by the regular landing Officer. When the man arrived on Houseblock 3 for the first time on 3 January, after being held in the healthcare centre and segregation unit, the regular landing officer made things happen. He was concerned by the man's bizarre behaviour on Houseblock 3 and made a careful written record of what he saw and heard. He rang the healthcare centre on the evening of 3 January and was assured by the clinical nurse manager that a mental health assessment of the man was already in hand. On the morning of 6 January, the regular landing officer rang the mental health team to find out what could be done for the man. After he had dropped the man off in the segregation unit for his resumed adjudication, the regular landing officer went in person to the healthcare centre and completed a mental health referral form at the request of his colleagues there. The regular landing officer might claim that he was merely doing his job but he used existing systems at Holme House to great effect for the man's benefit. Had it not been for the energy, determination and concern that the regular landing officer displayed, I think it most unlikely that any mental health assessment would have taken place before the man's death. As a housekeeping point I note in passing that Holme House were unable to retrieve the SIR that the regular landing officer wrote when my investigators requested it.

**I recommend that the five members of staff whom I have named should receive formal commendation from their Governor or the North East Area Manager.**

**Recommendations**

**I recommend that the Governor should consider whether a policy on constant observations, especially in camera cells, should be drawn up.**

**I recommend that urgent management attention should be paid by the Governor, healthcare manager, Primary Care Trust and local Mental Health Trust to the integration of the expanded mental health team at Holme House within existing clinical services so that the best possible value (both clinical and financial) is obtained from their skills and expertise.**

**Staff in the mental health team have enormous and critical skills to place at the prison's disposal. I recommend that the Governor makes use of the readily available talent within the mental health team to deliver a programme of training on mental health issues to selected staff as soon as possible.**

**I recommend to the Governor and PCT that a programme of defibrillator training for staff in the healthcare centre should be introduced without delay.**

**I recommend that the Governor ensures the CCTV equipment in the healthcare centre is fit for purpose and that staff have been adequately trained in how to use it.**

**I recommend that the policy statement (on Healthcare temporary use of safer cells and camera cells) be reviewed, especially if the intention at Holme House is to continue locating prisoners at risk of harm to others in camera cells.**

**I recommend that the Governor reviews arrangements at Holme House for ensuring that accused prisoners are fit to face disciplinary hearings.**

**I recommend, as a matter of urgency, that the Governor and Area Manager review arrangements at Holme House and other North East prisons for timely liaison with family members in the immediate aftermath of a prison death.**

**The Governor at the prison where the man's son formerly worked should review arrangements at that prison for timely liaison with family members in the immediate aftermath of a prison death**.

**I recommend that the five members of staff whom I have named should receive formal commendation from their Governor or the North East Area Manager.**

From the clinical review:

**I feel that it is good practice on reception to the prison to contact the prisoner's GP to get a full past medical history and a list of their current and past medication.**

**Patients who show signs of hallucinations and paranoid ideation should be offered urgent assessment of their mental state and be given medication in the interim to deal with their presenting behaviour.**

**Not all entries in the record had a time and name attached. I feel that doing so should be standard practice.**