# Investigation into the circumstances surrounding the death of a prisoner at HM Prison Holme House on 5 March 2005

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

**December 2005**

This is the report of an investigation into the death of a prisoner on 5 March 2005. The prisoner was a remand prisoner at HM Prison Holme House. According to the post mortem, the cause of death was hanging.

My Deputy Ombudsman and one of my investigators conducted this investigation. The North Tees Primary Care Trust also conducted a clinical review into the prisoner's care and treatment whilst at Holme House.

The prisoner appeared to have settled into the prison routine well, and was polite and compliant. There was no indication to staff, as a result of his actions or demeanour, that he was at risk of suicide or self-harm. However, the prisoner's brother, solicitor and his cellmate were allegedly aware of his intentions, but no one alerted the prison.

I would like to extend my condolences to the man's family for their loss. I would also like to thank the Governor of HMP Holme House, and his staff for their help and co-operation during this investigation. I would like to extend my thanks to Cleveland Police and Durham Constabulary for their assistance in this matter.

This final version of my report has been amended in a number of places to take account of comments from the prisoner's widow.

**Stephen Shaw CBE**
**Prisons and Probation Ombudsman** **December 2005**

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## Summary

At approximately 7.50pm on Saturday 5 March, prison staff at HMP Holme House were alerted to the fact that a prisoner had been found suspended from the cell window by a ligature around his neck. He was unconscious and not breathing. Assistance was sought from a member of the prison nursing staff who happened to be on the wing at the time when the prisoner was discovered. There was no effort to resuscitate the prisoner, as it was obvious to staff that he had been dead for some time. Paramedics also attended and concurred with the nurse's findings. The post mortem report indicates that he died as a result of hanging. The clinical review concludes that, whilst in custody, there was no deterioration in the prisoner's physical health although the acute problem with his diabetes probably deflected attention away from his psychiatric condition.

At the time of his death, the prisoner was sharing a cell with a fellow prisoner. During the course of our investigation, it became apparent that the prisoner, who could not read or write, had sent letters to his son and his solicitor in respect of his affairs. It transpired that the prisoner's cellmate had written these letters on the prisoner's behalf.

The prisoner's brother was not surprised on learning of his brother's fate and confirmed to the police that he often spoke about killing himself. The brother also said that he told the prisoner's solicitor about the prisoner's feelings. Unfortunately, no one alerted the prison. The prisoner had found his feet in prison and was polite and co-operative. There was therefore no reason for staff to believe he was at risk of suicide or self-harm.

To date, the police do not suspect foul play in this sad story. The prisoner's cell mate says he simply did not notice what the prisoner was doing.

This report makes two recommendations and identifies two areas of good practice.

## The Investigation process

1. The investigation was opened at HM Holme House on 31 March when the Deputy Ombudsman visited Holme House on a preliminary visit. The investigation proper took place on 4-5 May. The Governor and his staff produced the prisoner's core record and a number of other documents for examination. Notices were issued to staff and prisoners telling them of the investigation. My investigators were able to speak to members of staff

who knew the man or who were on duty at the time of his death. The investigators were also able to speak with Cleveland Police in relation to issues of common interest.

2. The North Tees Primary Care Trust conducted a clinical review of the prisoner's care and treatment. A representative from the Trust also took the opportunity of visiting Holme House with the investigation team and participating in the investigation process.

3. A Family Liaison Officer from my office, Lucy Phelan, wrote to the prisoner's family on 11 May informing them of my investigation and whether there were any concerns that they wanted to raise. A response was not received from the prisoner's widow until after a copy of the draft report had been circulated. In a letter, dated 18 August, the widow stated that she had handed in her husband's prescription to police on the day of his arrest and said that he had not received his prescribed medication for his mental condition whilst in custody. Without medication, the prisoner's wife stated that her husband was liable to take his own life. My Family Liaison Officer and my investigator met with the prisoner's wife on 14 November to discuss the draft report with her.

4. My investigators contacted and met with Mr Sheffield, HM Coroner, to inform him of the nature and scope of my investigation and to request a copy of the Post Mortem report. Upon completion, this report will be sent to the Coroner to assist him in his enquiries into the prisoner's death.

**The prisoner**

5. The prisoner was, according to the arrest warrants issued by the court, born on 1 April 1947. However, the available documentation also gives dates of birth as 1 April 1945 and 12 September 1945. We have not been able to confirm with the police whether the prisoner had any previous convictions, due to these discrepancies.

6. The prisoner was a tenant farmer at the time of his arrest. He lived on the farm with his wife and their five children. The prisoner had been married for approximately 27 years. The prisoner's brother also lived on the farm. It is believed that the prisoner was unable to read or write. It is also reported that he did not take alcohol or drugs.

7. On 4 February 2005, the prisoner was involved in an incident at a local garage with his eldest son whom he threatened to kill. He was arrested and taken to a local police station. During the course of police investigations, a number of other alleged offences came to light from family members. These included prolonged and sustained mental and physical abuse against members of the family. Following the circulation of my draft report, the prisoner's widow said in a letter dated 18 August, and during a meeting with my Family Liaison Officer and my investigator, that on the day of his arrest she handed her husband's prescription to police emphasising that, without his medication, the prisoner's mental condition would deteriorate. The prisoner's wife also said that whilst at the police station she arranged for a police officer on duty to speak with the prisoner's GP over the telephone in order to confirm her husband's mental status. A copy of the prisoner's custody record obtained from Durham Constabulary did not indicate that the prisoner had any mental health issues. Durham Constabulary has confirmed that on the day of his arrest the police surgeon did speak to the prisoner's GP by telephone. The conversation was noted in the police surgeon's notes. However, it would appear from the police custody record that the main concern at the time was controlling the prisoner's diabetes.

8. According to the prisoner's GP, he last saw the psychiatrist on 2 April 2004. At the time of his arrest he was prescribed Trazadone, Epilim and Olanzapine.

9. On 5 February, The prisoner was charged with a total of eight offences. These included two sexual offences and one of actual bodily harm. He remained in police custody that weekend.

10. On 7 February, The prisoner appeared before the North Durham Magistrates Court sitting at Newton Aycliffe. Initially, following a bail application, bail was granted to the prisoner with specific conditions. However, there was an appeal from the prosecution and he was remanded into custody to HMP Holme House. This appears to have been the prisoner's first term in prison custody.

11. The prisoner arrived at Holme House with over £2,200 in his possession. This was later paid by cheque to his brother via a letter sent from prison.

12. On reception at Holme House, the prisoner was channelled through the various aspects of the reception process. This included an induction interview. The prisoner stated that he was worried about his children. Due to the nature of the charges against him, the prisoner received an explanation of the opportunity for segregation under Rule 45 of the Prison Rules. Because of his illiteracy, a member of staff gave the prisoner assistance in completing the appropriate application forms. The prisoner was then seen by a duty governor and his request to be placed on the vulnerable prisoner's unit was approved.

13. It was noted at the time of his reception to Holme House that the prisoner stated that he had suffered a nervous breakdown in 2001, and that he had then tried to hang himself. On 7 February, the medical record indicated that the prisoner was not showing any obvious signs of mental illness. His mood was acceptable and his behaviour was appropriate. When questioned about his mental health and prescribed medication, the prisoner could not elaborate any further.

14. Throughout his period in custody, the prisoner did not give any indication to staff that he was contemplating any form of self-harm. As a result, the prison did not feel it necessary to implement the Assessment, Care in Custody and Teamwork (ACCT) procedure. It should be noted that the prison knew that he suffered from a number of physical conditions that included insulin controlled diabetes, epilepsy and a heart condition for which he had been taking medication.

15. On completion of the reception process, the prisoner was moved to the Health Care Centre for a period of assessment due to his physical health needs. The prisoner had suffered with diabetes for approximately 20 years. His brother used to administer the treatment, although his widow later stated that she used to try to administer medication to her husband. It was also established that the prisoner did not always adhere to the treatment regime for his diabetes and consequently it was uncontrolled.

16. On 8 February, the Health Care Centre sent an urgent faxed request to the prisoner's GP asking for the dosage of insulin that he was on. A response was received the same day and included Epilim, Olanzapine and Trazadone. However, this did not prompt any further investigation into his mental health status at that time. Indeed, the prisoner did not present a mental health problem to healthcare staff. The prisoner was kept in the Health Care Centre for observation that night.

17. On 9 February, following a consultation with the doctor, the prisoner was considered to be fit to be relocated to a normal residential unit. He was identified as being of 'medium' risk for cell sharing and, because of his vulnerable prisoner status, was moved to a block that accommodates vulnerable prisoners (houseblock three).

18. On 14 February, the prisoner returned to Holme House from Court having been again remanded into custody. His case had been adjourned for trial at Crown Court.

19. On 3 March, it is recorded that the prisoner was finding his feet in prison and describing him as being polite and compliant. It is also noted from interviews with staff that he had developed a good relationship with his cellmate. The cell mate was also identified as a medium risk in terms of sharing a cell, although he had stated on the assessment that he was homophobic. The cellmate had been placed on the vulnerable prisoners' unit because of perceived threats from other prisoners. The cellmate was serving a one-year sentence for affray. The two men had been sharing cell A2 (11) since 28 February. The cellmate has been described as an individual who found it difficult to cope and who may have learning difficulties. He is also described as having a manipulative nature. The cellmate had found it hard to settle down with previous cellmates. Staff recall that the prisoner tended to follow in his cellmate's shadow.

20. On the afternoon of 4 March, the prisoner's continuous medical record indicated that health care staff were not able to locate his treatment card or medical record. However, he was given medication for his diabetes and epilepsy.

**HMP Holme House**

21. Holme House is a category B prison for adult males, opened in May 1992. The prison primarily serves the communities of the Tees valley, South West Durham, East Durham and North Yorkshire. The prison was inspected in April 2005 by HM Chief Inspector of Prisons and her report will be published shortly.

22. The establishment expanded in the late 1990s, and currently has a capacity for 994 prisoners who are accommodated in six self-contained house blocks with a mixture of single and double cells. Block three accommodates vulnerable prisoners and those prisoners on induction.

23. Holme House offers a variety of employment opportunities within its modern workshop complex. These are complemented and supported by a purpose built education department that offers both part time and full time classes.

24. It was also identified during our investigation that Holme House was in the process of implementing community based primary care on each wing. This is seen as good practice and this development should be supported and encouraged across the whole prison. It was also evident from our investigation that health care staff were professional, mutually supportive and treated prisoners with a high degree of care and compassion.

**Events prior to the prisoner's death**

25. On 9 February, the prisoner was moved from the Health Care Centre to house block 3, B wing. Up to his death, the prisoner was accommodated in various other cells on the wing. On 28 February, the prisoner was moved into cell number 3A2 (11) which he shared with a cellmate.

26. Whilst in prison, the prisoner received domestic visits on 19 February, 22 February and 2 March from his brother, his sister and a friend. He did not receive any visits from his wife or children. They had moved away at the time of his arrest. The prisoner was scheduled to have another visit on 6 March 2005 from his brother and a friend. The prisoner also received legal visits on 16 February and 1 March.

27. A Senior Officer remembers seeing the prisoner at breakfast time (approximately 7.30am) on Saturday 5 March with his cellmate. The Senior Officer remembers yawning in the presence of the two prisoners and that a light hearted banter followed that was initiated by the prisoner's cellmate with the prisoner joining in. The prisoner appeared to be in a good mood.

28. During the course of the day, nothing untoward was noted and prisoners and staff complied with the schedule of core activities for the day.

29. At 5.45pm, prisoners were locked in their cells after association time. The cellmate and the prisoner lay on their respective bunk beds watching television. The cellmate stated to the police that he fell asleep watching the television and did not wake up until shortly before 7.50pm. The cellmate said that he lay asleep with his back to the television and did not hear or see anything as the cell was in relative darkness. The television remained on.

30. At 7.20pm, an officer checked the cells through the door flap as part of the standard prison roll call. He noted that the cell light was turned off and that the prisoner appeared to be asleep on the top bunk bed with his head facing the cell window, whilst his cellmate appeared to be asleep on the bottom bunk with his back to the television facing the cell wall. The cell is a single cell that is used to accommodate two persons and is small. At 7.30pm, the officer phoned through the roll call to the control room.

31. At approximately 7.50pm, a nurse was on her routine round on the wing in order to administer medication to prisoners. Two officers escorted the nurse. At about the same time, the officer was alerted by the cell buzzer on A2 landing. It was quickly established that the cell bell for cell A2 (11) had been activated. The officer attended the cell and opened the cell door flap. He noted that the prisoner's cellmate was directly on the other side of the flap and seemed to be very agitated and asking for a cigarette. The cellmate stated that, when he awoke from a deep sleep, he did not notice that the prisoner was hanging from the cell window because of the poor light. On seeing the prisoner, he had tried to get a response by talking to

him and touching his arms but a response was not forthcoming. The cellmate turned on the cell light. The prisoner had a ligature tied around his neck that was made from a piece of bedsheet. The other end of the ligature was tied around the cell window. The prisoner appeared to be lifeless and ashen in colour and his eyes were fixed and dilated.

32. The officer summoned assistance and opened the cell door. The prisoner's cellmate was taken immediately to a crisis cell further along the landing and a prison Listener was asked to sit with him. The officer, along with another officer, took the prisoner's body weight and snapped the ligature. The prisoner was placed in the recovery position on the cell floor and attempts were made to find a pulse. A pulse could not be detected. At 7.52pm, an ambulance was called. The governor and duty governor were also informed of the situation.

33. The nurse, who was on the residential unit at the time, attended the cell. She noted the prisoner's pallor and also attempted to find signs of life. A pulse could not be detected and the nurse and the officers at the scene concluded that the prisoner had been dead for some while. In light of the clinical condition of the prisoner, it was decided that resuscitation would not be appropriate and therefore it was not started.

34. The nurse left the cell and the officers moved the prisoner onto his back. The cell door was shut until the arrival of the police and the Coroner's Officer. The prison initiated and acted in compliance with their contingency plan in the event of a death in custody. The paramedics arrived at the prison at 8pm. The prisoner was pronounced dead at 8.34pm. At 8.30pm, the police arrived to begin their investigation into the circumstances of the prisoner's death. The Prison Service National Operations Unit was told of the prisoner's death at 9.38pm.

35. A hot debrief for staff directly involved took place later on that night. Staff stated that they had received an appropriate level of care and support from management since the prisoner's death. The governor also sent a letter of thanks to staff for their efforts in dealing with the tragedy. This is seen as good practice, conveying a strong message of support and gratitude as well as compassion to junior members of staff who have dealt with a traumatic incident.

**Events after the prisoner's death**

36. Cleveland police took a statement from the prisoner's cellmate immediately following the discovery of the prisoner's death. The cellmate is described by staff as a man with learning difficulties. In his statement to the police, the cellmate recounts that the prisoner had frequently talked about suicide, but that he did not think of alerting staff because he had been successful in dissuading the prisoner from this course of action. Mr Bailey states that the prisoner was feeling down but that his efforts to cheer him up appeared to be working.

37. The cellmate claims that he did not see or hear the prisoner hang himself, as he was asleep on the lower bunk bed with his back to the television. The cell was in relative darkness although the television remained on. Indeed, the cellmate has maintained to police on two occasions that he was in a deep sleep, with his back to the prisoner when he hung himself. He therefore, did not see or hear anything suspicious. The cellmate has been contacted by the Ombudsman's office at his forwarding address. To date, the cellmate has not responded to our communications and it is felt that he is unlikely to assist with our enquiries into the death of the prisoner.

38. A search of the cell revealed a letter, purportedly written by the prisoner to his youngest son, that appeared to be settling his affairs. It was strongly suspected that the prisoner was illiterate. During the course of the police enquiry, it was soon established that the cellmate had written several letters over the preceding week for the prisoner who dictated the content. A letter had also been sent to the prisoner's solicitor detailing what should happen to his estate in the event of his death. The solicitor acting on behalf of the prisoner does not appear to have interpreted the letter as indicating anything untoward nor to have alerted the prison as to the prisoner's possible intentions.

39. Police also took a statement from the prisoner's brother who had visited him whilst he was in prison. His brother said that during the visits the prisoner had spoken to him about taking his own life because of his situation. On 28 February, his brother was so concerned that he contacted the prisoner's solicitor to voice his concerns. The prison was not made aware of his intentions either through the solicitor or the brother and therefore did not take any action. The prisoner's brother is upset that the solicitor did not inform the prison of the prisoner's threats to self-harm.

40. The prisoner had also told his brother that he had attempted suicide by electrocution in his cell. The prisoner had spilt water by his feet and had attempted to use the kettle lead to conduct electricity. The attempt failed. The prison was unaware that this was a serious attempt at self-harm. The incident was reported to staff, and subsequently recorded, as accidental damage to the equipment.

41. Following the discovery of the prisoner's body, the cellmate was moved from the crisis cell to the healthcare centre for observation. His behaviour

was deemed strange in that he wanted to return to the cell he shared with the prisoner to obtain a bottle of Radox that belonged to the prisoner. He was also seen to be in a jovial mood by staff working in the Health Care Centre. This was also considered to be strange under the circumstances.

42. The cellmate served out the remainder of his custody in the Health Care Centre and was subsequently released from Holme House on 9 March to a probation hostel (approved premises) in York. The police were able to interview the cellmate at this location on 12 April on the direction of the Coroner. At interview, the cellmate maintained that although he was aware of the prisoner's intentions, and that he had written letters on his cellmate's behalf, he did not see, hear or assist in the prisoner's death. At interview, he was described as co-operative.

43. Following the prisoner's death, efforts were made to contact the prisoner's brother, the nominated next of kin, but this proved to be unsuccessful. However, senior managers were aware that he was due to have been visited the next day by friends. The decision was therefore made to delay informing the next of kin until contact details could be obtained the following day from the visitors.

44. On 6 March, the prisoner's visitors were seen by the Governor and deputy governor and informed of the prisoner's death. A contact number was obtained for the prisoner's family to inform them officially of the death. In the meantime, the prisoner's friends had already contacted the prisoner's brother and told him the death. The prisoner's widow stated that on the day of her husband's arrest she had moved away from the area. The prisoner's widow was told of her husband's death through an acquaintance of her husband's by telephone. She then contacted the police who were able to confirm it.

45. Prisoners and staff were informed of the prisoner's death on 6 March. The mood of the wing was described as sombre.

46. The prisoner's widow visited the prison and spoke to a governor about her husband's death. During the visit she asked whether her husband had been receiving his medication. The widow was told that he had been receiving treatment for his diabetic condition, but was not able to confirm that he had received any appropriate treatment for his mental illness. The prisoner's widow was adamant that without medication her husband was likely to self-harm. She remains very upset that his mental condition was not detected or treated.

47. The prison sent a letter to the prisoner's widow offering their condolences and financial support towards the funeral. She claimed that she had never received the letter. However, it is noted she moved away shortly after the prisoner's arrest. Following a visit to the widow by my Family Liaison Officer and the investigator, a copy of the invoice for the prisoner's funeral has been forwarded to the Governor for his consideration.

48. The prison informed the Prison Service's National Operations Unit (NOU) of the death of the prisoner on the night it occurred. Unfortunately, the NOU failed to inform the Prisons and Probation Ombudsman of the death. It was only after a call to our office on 29 March, requesting to know the lead investigator, that we were alerted to the case.

**Clinical Review and Post Mortem report**

49. North Tees Primary Care Trust undertook a clinical review of the prisoner's care and treatment whilst he was at Holme House. The review confirms that the prisoner had a history of unbalanced diabetes, epilepsy and coronary heart disease, and that prescribed medication also indicated he had mental health problems and depression. Indeed, the review suggests that the acute problem with the prisoner's diabetes probably deflected the attention away from his past history of psychiatric illness. At the time of his admission to Holme House, there was no indication that the prisoner had a psychiatric condition. This condition would have been known had the prison been able to obtain the prisoner's previous medical history from his GP or hospital.

50. The post mortem report indicates that the prisoner was suffering from a number of medical problems consistent with his age. However, the report concludes that he died simply as a result of hanging. There was no evidence that he was restrained or the victim of assault and thus foul play was not suspected.

## Findings and conclusions

51. The prisoner was treated properly on reception at Holme House and received the appropriate care and treatment for his known medical conditions whilst in custody. Although the prison was aware that the prisoner tried to hang himself in 2001 as a result of a nervous breakdown, there was no indication given to staff that he intended to harm himself again. However, the prisoner's solicitor, the prisoner's brother and his cellmate were all apparently aware of his threats but failed to alert the prison. In respect of the apparent failure by the prisoner's solicitor to alert the prison to the prisoner's intention, despite the receipt of a letter and concerns voiced by his brother, the police have asked the solicitors to comment. To date, the solicitors have refused to co-operate with the police and this remains the subject of an on-going enquiry.

52. In response to my draft report, the prisoner's widow said that she passed the prisoner's prescription to police on the day of his arrest. She added that she told police that, without his medication, the prisoner's mental condition would deteriorate, implying that he might attempt self harm. A copy of the prisoner's police custody record was obtained, but does not indicate any mental health issues or any medication that was handed to police.

53. On reception at Holme House, the prisoner's past medical record, including his past psychiatric history, was not made available. Consequently, a full and proper assessment of his mental state could not have been made. However, the Health Care Centre was made aware by his GP of the medication that the prisoner was in receipt of at the time of his arrest. This included, Epilim, Olanzapine and Trazadone. However, this knowledge did not prompt further investigation by health care into the prisoner's mental health status, although the medical record indicated that medication was administered.

54. Police enquiries to date have not identified anything suspicious surrounding the circumstances of the prisoner's death that would warrant further investigation. The prisoner's cellmate claims that he was asleep at the time and therefore did not see the prisoner hang himself. The cellmate's strange behaviour was noted but was seen as symptomatic of his character.

55. Although it is evident that the prison took the appropriate and timely action in informing the National Operations Unit of the death of the prisoner, it is unfortunate that the Prisons and Probation Ombudsman's office was not notified promptly. Regrettably, this has occurred on a number of occasions and NOU will wish to review its procedures to ensure they are robust.

## Recommendations

The National Operations Unit (NOU) should review its procedures for informing the Prisons & Probation Ombudsman of deaths in custody to ensure that the investigation process can be started in a timely manner.

The Governor of Holme House should remind healthcare staff that, where prisoners have significant medical or psychiatric conditions, their GP or hospital doctor should be contacted to provide details of the patient's previous medical history as well as their present medications. Access to this information may give the prison a more comprehensive medical and mental state of the prisoner and thus allow the prison to take timely, effective and appropriate action and treatment. In instances where it is known where a prisoner is in receipt of anti-psychotic or anti-depressant medication, this should prompt further investigation, irrespective of the patient's presentation.

## Good Practice

The development of primary care clinics on the residential units at Holme House echoes the concept of primary care delivered in the wider community, and its continued expansion to the whole prison should be encouraged and supported.

The personalised letters from the Governor thanking staff for their efforts in responding to the finding of the prisoner's body are an example of good practice.