# Investigation into the circumstances surrounding the death of a man, whilst in the custody of HMP Holme House, in 2007

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

**November 2007**

The man, a Polish national aged 21 years, was found hanging in his cell at HMP Holme House in June 2007. He had used his bed sheet as a ligature tied around his neck and attached to his cell toilet door. Staff responded immediately and resuscitated him. Sadly, despite their best efforts and those of the medical profession, he did not regain consciousness and died in hospital nine days later in July 2007. His mother was at his bedside.

I would like to add my sincere condolences to those already expressed by staff and prisoners at Holme House to the man's family and friends for their loss.

The man was a convicted unsentenced prisoner. He had pleaded guilty to serious offences and was expecting to be sentenced the week after he was found hanging. This was his first time in a British prison.

One of my investigators conducted the investigation. The North Tees Primary Care Trust conducted a clinical review into the man's care and treatment whilst at Holme House. I would like to thank the Governor of HMP Holme House, and his staff for their help and active co-operation during this investigation. I am also grateful to the Cleveland Police for their ready assistance. The man's apparently self inflicted death occurred within days of another death at the prison. My investigator is satisfied that they are not linked.

The man's family and family representives have been in contact and visited Holme House. They have also been in contact with one of my Family Liaison Officers from an early stage. A key part of the investigation was to ensure the family had the opportunity to raise their concerns.

The man's spoken English was good and he was described as a well-behaved prisoner. Although in retrospect it would appear that he became more inward-looking, he did not give staff or other prisoners any cause for concern. His death was a shock to all who knew him.

I refer in my report to some excellent practice at Holme House including an impressively detailed, speedy and caring response to the man's death and excellent prison family liaison. Officers interviewed offered their condolences to the man's family.

Unusually, I make no formal recommendations.

This version of my report has been anonymised for publication on my website.

**Stephen Shaw CBE**
**Prisons and Probation Ombudsman** **November 2007**

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## SUMMARY

In January 2007, the man was received together with his two co-accused into HMP Holme House. They were jointly charged with serious offences and had appeared at Newton Aycliffe Magistrates' Court earlier in the day. Upon reception, staff found the man's spoken English to be very good. He was found to pose a low risk of harm to others and was deemed suitable for sharing a cell.

A First Reception Health Screen was completed. The man said he had taken an overdose of tablets three years earlier but had no current thoughts of self harm or suicide. He said he took amphetamines two or three times a week, used crack cocaine monthly and drank half a litre of vodka daily. It was recorded that he had a cut on his right hand. He reported having a nose bleed on two nights earlier following a fight and was concerned about his right knee which was slightly swollen following an accident.

The man and his co-accused were initially located on House Block Three but subsequently moved to House Block Four. He settled into prison life quickly, and was consistently described as polite and respectful, regularly attending education and gym classes.

The man was involved in a fight with his cell mate in February, and sustained a small red mark on his back. His cell mate, a fellow Polish national, was transferred to HMP Durham the following day.

On 12 March, the man and his co-accused pleaded guilty to the charges they faced at Teesside Crown Court. They were returned to Holme House, House Block Four pending sentencing. Staff were consistently positive in their comments when describing his behaviour.

On 25 May, an entry was made in the man's history sheet saying he was a bit down and not getting on with his cell mate. The man was reassured by staff that they would move him when they could. On 11 June, he was moved to another cell , a larger cell that he shared with a prisoner. The man's cell mate said, they both got on well together.

On 22 June 2007, the man's cell mate discovered the man hanging in their cell by a ligature attached to the toilet door. He immediately shouted for assistance, and himself took the man's body weight to reduce the tension on the ligature. With the help of staff the man was cut down and placed on the floor. Staff and paramedics carried out resuscitation and he was taken to hospital where he died on 1 July with his mother at his bedside. Sadly, he never regained consciousness.

A post mortem examination took place on 3 July. It found that the man had died as a result of hanging and there was no evidence to suggest third party involvement. The man had given no outward indication to staff or fellow prisoners that he intended to take his life.

## THE INVESTIGATION PROCESS

1. The investigation was formally opened at HMP Holme House on 2 July 2007 by my investigator. The Deputy Governor and her staff produced the man's core record and a number of other documents for examination. My investigator met with members of the chaplaincy, Prison Officers' Association (POA) and Independent Monitoring Board (IMB).

2. Notices were issued to staff and prisoners informing them of the investigation and inviting anyone with relevant information to make themselves known to the investigator. My investigator was given unrestricted access to the prison, staff, prisoners, and documentation relating to the man. He was also able to speak with Cleveland Police in relation to issues of common interest.

3. Prison officers, members of health care staff and prisoners were formally interviewed, and those interviews were tape recorded. The services of an official interpreter were used to assist my investigator interview two Polish prisoners (the man's co-accused). The interviews have been transcribed and interviewees invited to sign and return them. Although not all transcripts have been returned signed, they are attached as annexes to this report. The man's criminal solicitor has not been contacted as part of this investigation. A copy of this report will be translated into Polish for his mother.

4. The North Tees Primary Care Trust conducted a clinical review of the man's care and treatment. A representative from the Trust also took the opportunity of visiting Holme House.

5. A Family Liaison Officer from my office, contacted the man's family spokesperson, who asked the following questions:

    - How did the man manage to hang himself in his cell?
    - Are there any known reasons why he decided to take his life?
    - Did he see a doctor during his time in the prison and, if so, what for?
    - Did he have any fights in prison?
    - Were there any concerns regarding other prisoners, e.g. bullying, owing debts, etc?
    - The man's cell mate was at work when he hanged himself – was the door locked or unlocked? Open or closed? Were there any staff on the landing and where were they at the time?
    - The family were told that the cell mate had been out of the cell for approximately 30 minutes, and asked the investigation to establish the timing of events.

6. My investigator wrote to 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 his enquiries into the man's death.

## BACKGROUND

### HMP Holme House

7. Holme House is a category B prison for unconvicted, convicted and sentenced male adults. It opened in May 1992. The prison primarily serves the communities of the Tees Valley, South West Durham, East Durham and North Yorkshire. It has a total of six residential units, known as House Blocks One to Six. It has an operational capacity (maximum crowded capacity) of 994.

8. House Block Four is used for remand prisoners. My investigator found it clean and well maintained. The purpose built double cells have privacy doors separating the toilet from the living area.

9. In common with other establishments, Holme House runs a personal officer scheme for prisoners. Officers are responsible for the prisoners in a specified number of cells and cover in each other's absence.

### Suicide and self harm monitoring

10. As at all prisons, Assessment, Care in Custody and Teamwork (ACCT) has been introduced at HMP Holme House to monitor and support prisoners assessed as at risk of suicide or self harm. (The previous system was known as the F2052SH procedure.) Once placed on ACCT, the prisoner is observed at pre-determined intervals according to the perceived level of risk.

11. Each prisoner is assessed within 24 hours and then reviewed at intervals decided on an individual basis. The ACCT guidance says that, to be effective, the review should involve the key people who know the person at risk or are involved in their care. The key questions for each review are listed as:

    - have the problems that caused the ACCT plan to be opened now been resolved?
    - if not, what needs to be done to resolve them?
    - have any further problems arisen that are now causing distress and more risk?
    - if so, what action can be taken to address these?
    - is the person at risk now in contact with friends, family or other support?
    - does the person at risk now have something in their lives that they feel good about?
    - if not, how can this be improved?

12. Over time, the reviews should also consider other factors such as:

- distress – has anything changed to make the person at risk more or less desperate?
- resources – has anything changed that makes the person at risk now feel more or less alone?
- previous suicidal behaviour – has anything changed that makes suicide more familiar or more acceptable to the person at risk?
- suicide intention or plan – has anything changed to show that the person at risk is more or less prepared to kill themselves?
- pattern of self harm – is self harm becoming more or less frequent?

13. Amongst other things, the ACCT guidance states that prisoners should be cared for in a safe environment and it is for the Case Review team to decide the most appropriate place to locate an individual prisoner. The man was not identified as a prisoner at risk of self harm and was therefore not subject to self harm monitoring

**Listeners**

14. Listeners are prisoners trained by the Samaritans to offer confidential support for prisoners in distress. The Listener scheme has been running for eight years at Holme House. In addition, prisoners have confidential access to Samaritan phones for support in times of distress. There is no evidence to suggest that the man used the Listener facilities.

**Previous deaths at Holme House**

15. The man's death was the sixth apparently self inflicted death to have occurred at Holme House since April 2004 when I became responsible for all investigations into deaths in prison custody. Sadly, another apparently self inflicted death occurred in another part of the prison on 27 June 2007. My investigator is satisfied that there are no links between the two tragedies.

**HM Chief Inspector of Prisons' Inspection**

16. HM Chief Inspector of Prisons, Ms Anne Owers, conducted an inspection of Holme House in April 2005. She found Holme House to be a largely safe and well-ordered establishment, and suicide and self-harm prevention was well managed. Many of the prisoners most likely to be at risk of self-harm were diverted to beds in the healthcare centre upon reception.

17. Ms Owers judged that there was a good range of clinical services delivered by a well qualified, experienced and committed healthcare team. Prisoners had good access to primary care through the introduction of wing based surgeries and the attendance of visiting health professionals. Inpatients were well cared for in a therapeutic environment and were encouraged to participate in the available regime. Joint work with North Tees NHS Primary Care Trust was underpinned by strong leadership from both organisations, and there had

been a successful transfer of the commissioning of healthcare to the PCT in April 2005.

18. Holme House provides 24 hour nursing care for prisoners. Two full time medical officers, one of whom was a general practioner (GP), were employed full time at the prison by the Primary Care Trust. Out of hours medical cover was provided by a local GP practice.

19. HM Chief Inspector of Prisons found healthcare staff had a strong team ethos and demonstrated an enthusiastic and professional approach to the care of patients. A trained nurse saw all new prisoners in reception and completed a health screening and Well Man assessment. Prisoners identified with a problem or chronic illness, such as asthma or diabetes, were noted on a chronic disease register and followed up by the House Block or other specialists.

20. Any prisoner on a long sentence who appeared to be coping poorly was offered a bed in healthcare for a period of assessment. Prisoners who needed alcohol or drug detoxification were also offered a bed in healthcare. Some refused this option and went straight to the House Blocks. Prisoners could see the doctor in reception or in healthcare if they wished. All those with a serious medical condition saw the doctor within 24 hours.

**Foreign National Prisoners**

21. In the last ten years, Prison Service statistics show the number of foreign nationals in prison has doubled. They now represent over 14 per cent of the total prison population in England and Wales. It is evident that language and cultural differences present a huge challenge both to the Prison Service and to the individual prisoners themselves.

22. I welcome the proactive steps the Prison Service has taken in catering to the differing needs. Many establishments hold regular meetings between staff and prisoners to discuss the challenges facing foreign nationals such as immigration status, staying in contact with family, language difficulties and resettlement. In addition, the booklet 'Information and Advice for Foreign National Prisoners' is available across the prison estate in 22 languages and contains substantial information on issues including prison regimes, support organisations and contacting families. The Prison Service is also working to build closer relationships with Embassies and High Commissions, some of whom provide their own literature catering directly for their imprisoned citizens, as well as consular assistance.[1]

23. A British Asian has been a prisoner at Holme House. He is a sentenced prisoner and has been there over twelve months. He is a prisoner representative on race relations meetings, black and ethnic minority and foreign national meetings. He sits on boards with the Governing Governor, senior managers and the race relations officer. He uses those forums to

[1] Prison Service website

discuss the prison and prisoners' concerns.

24. The prisoner told my investigator in interview that his experience at Holme House had been a positive one, and felt that if a prisoner was showing signs of distress they would be helped. Although he had no independent recollection of the man, he attended the inaugural Foreign National prisoners meeting at Holme House and recalled giving advice to Polish nationals. It is known that the man was present.

25. At the time of my investigation, there were over 60 foreign national prisoners at Holme House. A new Diversity Manager had been appointed who held her first black and ethnic minority prisoners meeting on 24 May 2007. She met the man at that meeting and spoke to him after it had finished. She told my investigator that, in addition to induction booklets printed in different languages and the use of telephone interpreting services, foreign national prisoners receive a free five minute telephone call every month to their home country as well as any other calls they make.

## KEY FINDINGS

26. In January 2007, the man and his two co-accused, who were brothers, appeared at Newton Aycliffe Magistrates' Court charged with serious offences. They were all remanded into custody and taken by prison escort contractors to Holme House. They went through the reception process together. A Cell Sharing Risk Assessment (CSRA) was completed for the man and he was found suitable for cell sharing.

27. A First Reception Health Screen Form was completed by healthcare staff. The man gave a history of a recent nose bleed and was concerned about his right knee which was slightly swollen after an accident on 3 December. He was identified as a Polish national who spoke good English but had difficulty reading the language. When asked about substance use, the man said he drank half a litre of vodka daily, used amphetamines two or three times a week and took crack cocaine monthly.

28. The man and his co-accused were initially housed in House Block Three and moved to House Block Four on 18 January 2007. According to staff, they quickly settled into the prison life. There were other Polish nationals on the wing. The man and his co-accused attended gym classes and education for foreign nationals.

29. The man was given a hepatitis B injection on 7 February and reported that he might have contracted a sexually transmitted disease. An appointment was made for him to see the doctor the next day but he failed to attend as he was at education.

30. The man failed to attend for a further hepatitis injection on 21 February, and it was finally administered on 26 February. He was seen by a member of healthcare staff on 19 March for a lump on his penis and passing blood from his bottom. The clinical reviewer is satisfied that he received appropriate treatment.

31. One of the man's co-accused told my investigator that the man used to behave strangely and it was normal for him not to speak for a week or two and not go to association or to the gym. Because he and his brother saw this as normal behaviour they did not give it any further attention. The man did not give his co-accused any indication that he intended to take his life. One of the man's co-accused was aware that the man's father had committed suicide in Poland a year earlier.

32. The second co-accused knew the man well and said they all settled quickly into Holme House. He said that relationships between staff and prisoners were good, and that he and the man spoke and understood English. He said the conditions at Holme House were good, and that he had not encounted any problems. He also noticed that the man had stopped talking to him and his brother and going to association. He thought that the change in the man's demeanour was because their court case was getting nearer and he was expecting a substantial sentence.

33. The man's last cell mate is a prisoner at Holme House who carries out duties as a wing cleaner. In light of his job, his cell door is unlocked for most of the day. The man was located in the cell with his cell mate on 11 June 2006. They shared the cell for ten days. The man and his cell mate had a larger than normal cell equipped with two beds, toilet, basin and television. He said they got on well together and the man was good company. They played cards, went to the gym and watched television together. The man could speak and communicate well in English and got on well with staff and other prisoners.

34. Several officers spoke to my investigator about their memory of the man. An officer who works on House Block Four and is responsible for the care of prisoners on landing one. He recalled the man as a prisoner who never gave him any cause for concern, and went to education to improve his English, and to the gym. He often saw the man playing pool, table tennis and speaking to his co-accused. He said that the man was always polite towards staff and, when asked to do something, would do it straight away. The man was legally represented for his trial, but there has not been any communication between those representing the man and my investigators.

35. Another officer recalled the man as a prisoner who appeared to interact well, and attended the gym and education. He too said that his spoken English was very good.

36. A third officer who works on House Block Four and knew the man and his co-accused well. She described him as physically fit, always going to the gym, and as polite and respectful. She made a point of regularly talking to him and asking how he was. She said that he was a prisoner who never gave her any cause for concern.

37. The man had asked this officer for a cell move because the cell that he was sharing on landing three was quite small. She was aware that a cleaner on the first landing was in a larger double cell on his own and, as cleaners' cell doors are unlocked most of the day, they have to share with a prisoner who can be trusted. It was her decision to move the man from landing three to landing one as he was deemed a trustworthy prisoner.

38. The man had a personal officer. She saw him frequently on the wing. She said that if he had any problems he could speak to her, but he was always in good spirits, attending education and gym classes. She said he had no problems, was a happy prisoner and always had a smile on his face. He was polite and used to mix with other prisoners. She said that there was no evidence that he was the victim of bullying. The man was pleased that he had moved into a bigger cell with a cleaner as it meant that his cell door was left unlocked longer.

39. A Principal Officer (PO), a newly appointed Race and Diversity Manager at Holme House. She first met the man at the inaugural meeting of the Black and Ethnic Minority Prisoners Group. She described him as very supportive

of other prisoners who could not speak English. He appeared to her to be assertive, very polite, and helped other prisoners understand what she was saying. The man asked the PO at the end of the meeting how he could ensure that his passport would be safe if it was sent in to the prison, and she was able to advise him.

**22 June 2006**

40. The man's cell mate told my investigator that on the morning of 22 June their cell door was open as usual at 8.00am for breakfast. He went to get his breakfast but, unusually, the man stayed in bed. When he returned a few minutes later with his breakfast, the man was getting dressed. The cell mate ate his breakfast and at 8.45am was collected by an officer to clear the ground of litter outside the cell windows. He returned to their cell within 15-30 minutes. He saw the man standing beside the toilet door. He greeted the man and immediately realised that something was wrong. He saw that the man had a ligature attached to his neck and it was apparently suspended from the upper toilet door hinge.

41. The cell mate shouted for assistance and lifted the man off the ground around his waist to take the weight off the ligature. Within seconds staff arrived and cut the ligature to lower the man to the ground. The cell mate said the only difference he noticed in the man that morning was that he did not have his breakfast. He had given his cell mate absolutely no indication of his intention to self harm. The cell mate rejects any suggestion that the man was bullied.

42. An officer was going into the central wing office when he heard someone shouting for assistance. He ran to the man's cell with other officers. He saw the door was slightly open and that the man's cell mate was lifting the man off the ground. The officer used his Prison Service issue anti-ligature knife to cut the green bed sheet that had been used as a ligature

43. The man was placed on the ground, and the officer, who had received first aid training and attended a heart start course, immediately commenced Cardio Pulmonary Resuscitation (CPR) by giving the man chest compressions. As he was doing this he was joined by healthcare staff who took over resuscitation using a face mask, oxygen, and a defibrillator.

44. A second officer responded immediately to the call to the man's cell and, upon his arrival, saw his cell mate holding him and taking the weight of the ligature around his neck. The second officer saw the officer cut the ligature and they laid the man on the floor. The second officer attempted to limit movement to the cell. He told my investigator that the ambulance arrived very quickly.

45. A Registered Mental Health Nurse (RMN) and his colleague, a Staff Nurse, responded to a call over their prison radios to attend the man's cell. They took over responsibility for resuscitation, maintaining the man's airway with a face mask and oxygen, and carried out chest compressions. They were joined by two prison doctors. A defibrillator was attached to the man's chest

which indicated that his heart was active. When the ambulance crew attended they took over resuscitation and took the man to hospital.

46. A third officer was on the telephone in the central wing office on House Block Four when she heard a prisoner shouting for officers to attend the first floor landing. She too ran to the first landing, pressing the general alarm as she went. She got to the man's cell and was told by an officer that it was a Code Blue, meaning that it was an airway obstruction. She immediately radioed code blue to the prison control and gave her location. She saw the man lying on his back on the floor, and staff carrying out resuscitation. She instructed officers surplus to requirements to leave the cell, and placed two pillows under the man's legs to aid his circulation.

47. The officer said she became visibly upset and cried as she could not believe it was the man. She said of all the prisoners he was so nice, he was absolutely no trouble whatsoever, did not use drugs, and was always respectful. He did not seem the type that would be depressed. The officer managed to compose herself and took responsibility for keeping the log of movement in and out of the cell.

48. The log shows that the emergency code blue call was made at 9.13am. The ambulance crew arrived at 9.30am and left the cell with the man at 9.40am. At 9.50am, in accordance with Holme House's contingency plans, the cell was locked and padlocked pending a police investigation. The police are satisfied that there is no third party involvement.

49. Having reviewed the incident paperwork, my investigator is satisfied that the contingency plans at Holme House were successfully implemented. Healthcare staff were notified and immediately attended the man, and the ambulance crew's entry and exit to Holme House was unrestricted. A hot debrief took place for staff involved in the incident after the man had gone to hospital. An officer said staff were shocked that it was the man, but all felt they had done all they could. Those staff involved were personally thanked in a written letter by the Governor, and generally felt well supported.

50. The man was taken under escort to hospital. He was not physically restrained but prison staff kept a discreet continuous watch on him. The man's mother was contacted and arrangements were made by the prison for her to travel to her son's bedside from her home in Poland. She was at his bedside when he died at 11.40pm on 1 July 2007, without having regained consciousness.

51. The sad news of the man's death was communicated to prisoners and staff verbally and by written notice. The man's cell mate, other prisoners and staff, have generally felt well supported at Holme House following the discovery of the man and his subsequent death.

**Post Mortem**

52. A post mortem examination on the man was conducted by a pathologist on 3 July at North Tees General Hospital. It was the pathologist's opinion that the cause of death was hypoxic brain injury entirely consistent with hanging. There was no suggestion of anyone else's involvement.

**Contact with family**

53. The Deputy Governor worked hard to notify the man's mother of her son's transfer to hospital, eventually tracing her in Poland through the family of her son's friends in Darlington. She was offered help with costs of travel. The chaplaincy arranged for a Polish speaking Roman Catholic priest together with the Deputy Governor to meet her and family friends at the hospital. After her son's death, his mother visited Holme House where she saw her son's cell and spoke to Polish prisoners on the wing. The funeral costs and the cost of repatriating the man's body back to Poland have also been offered by Holme House.

## ISSUES CONSIDERED IN THE INVESTIGATION

### The discovery of the man hanging

54. When the man's cell mate discovered him hanging he immediately shouted for assistance and took his body weight to relieve the tension from the ligature. Staff acted quickly and professionally by cutting the ligature and placing the man on a firm surface. They commenced and continued resuscitation until the arrival of the ambulance crew. My investigator was impressed by the effectiveness of the prison's contingency plans in ensuring the quick entry and exit of the ambulance.

55. Whilst at hospital the man remained unconscious and a decision was made not to physically restrain him. Officers keeping bed watch did so by keeping a discreet distance and being sensitive to the needs of the man's mother and friends.

### Clinical care

56. The clinical reviewers judge that the man's initial reception screening documentation was complete. The risk assessment checklist had been finalised within timescales and was found to be a proper record.

57. The outcome of the screening process identified the man as receiving no medication and having no mental health issues, other than a previous overdose about three years ago. Details of his physical health were taken at reception. He did not disclose any recent thoughts of suicide or self harm. He raised concerns about his right knee, which was noted as being slightly swollen following an accident. During the man's stay at Holme House he complained that he might have contracted a sexually transmitted disease. He was seen in triage on 7 February and 19 March 2007, and the clinical reviewers assess that appropriate treatment was given. It is not clear whether any attempt to obtain the man's previous medical records had been undertaken.

58. The clinical reviewers are of the opinion that the level of care proved to the man was appropriate. He did not need to be referred to other agencies and therefore no contact was made.

59. The man's contemporaneous medical record was completed, dated and signed, and the care plan was complete and very clear. However, there were some occasions when entries into the care record failed to include the time of intervention. This is a recurring theme in my investigations and, whilst I make no formal recommendation, the Governor should remind staff of the importance of signing, dating and timing entries in all records.

*60.* A full history was obtained which identified that the man had previously taken amphetamines two to three times a week. He was not referred for drug and alcohol support services. There were no indicators of suicide or self harm identified in the screening process or throughout the care plan. The man did

not receive any detoxification treatment. The clinical reviewers say policies and procedures are in place and meet the Department of Health and Prison standards. The death of the man was reported promptly through the Primary Care Trust incident reporting system.

**Foreign National Prisoners**

61. Holme House is working hard to embrace all foreign national prisoners. The appointment of the first full time Race and Diversity Manager is a statement of the establishment's intent. My investigator was impressed by the enthusiasm shown by the manager and the positive feedback from a prisoner representative. Whilst I make no formal recommendation, it is acknowledged by HM Chief Inspector of Prisons and the Diversity Manager that dedicated administrative support would aid her effectiveness, especially with the increasing number of foreign nationals who find themselves in custody.

**Family concerns**

62. My investigation has outlined in this report the circumstances and chronology on the morning the man was discovered. The family asked whether there was any known reason why he decided to take his life. It is apparent that he appeared a little more remote to his Polish co-accused but they, his cell mate and staff, noticed nothing in his demeanour that gave them any cause for concern. His co-accused believed that the man would receive a more substantial term of imprisonment than them. They were also aware that his father had committed suicide a year earlier, but this information had not been shared with the prison.

63. The family asked whether the man had seen a doctor whilst in prison. The details of his contact with healthcare staff have been outlined earlier. The family also wanted to know whether he had been involved in any fights and whether he was the subject of any bullying. As I have shown, the man was involved in a fight with a Polish cell mate and sustained a red mark on his back. The cell mate involved was transferred the following day. There is no indication from staff or prisoners, particularly the man's cell mate, that the man was being bullied or was in debt.

64. The prison worked hard to notify the man's mother about what had happened to her son, paying for her flight from Poland and using the service of a Polish speaking Roman Catholic priest to facilitate communication once she had arrived. After his death, his mother visited Holme House and spoke and asked questions of staff and prisoners who knew her son.

## CONCLUSION

65. The man was consistently described as a decent, well-behaved prisoner who was known and liked by staff. He had pleaded guilty to serious offences and expected a substantial custodial sentence. That said, it is clear that his death came as a complete surprise to those that had dealings with him. Outwardly, he gave those that knew him - his co-accused, his cell mate, fellow prisoners, and staff - no indication of the distress that he must have been suffering.

66. When he was discovered hanging, his cell mate acted quickly. Staff commenced resuscitation immediately and ensured the unhindered entry and access to the prison by the ambulance staff. I do not believe that the man's final actions could have been predicted by staff at Holme House.

### Good Practice

67. I have been most impressed by the prison's response to finding the man hanging and then to his death. The prisoner and staff who first found him responded quickly and efficiently to the emergency. The family liaison was sensitively handled, with the Deputy Governor taking personal responsibility for ensuring the man's mother was able to attend the UK, and for ensuring his body was repatriated to Poland.

68. The Governor may wish to consider if formal commendations are appropriate both for his staff and for the man's cell mate.