PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent investigations

Investigation into the death of a man whilst in the custody of HMP Durham in May 2012

Report by the Prisons and Probation Ombudsman for England and Wales

January 2013

This is the report of the investigation into the death of a man, who was found hanging in his cell at HMP Durham in May 2012. I offer my condolences to his family and friends.

The investigation was carried out by one of my investigators. A clinical review was conducted by a clinical reviewer. Durham prison cooperated with the investigation.

The man was charged with a serious offence and remanded into prison custody in March 2012. This was his first time in prison custody. Although it was noted that he was of low mood when he first arrived at Durham, he was not identified as a risk of suicide or self-harm. I am concerned that this risk was not further assessed when he returned to the prison having been subsequently questioned by the police about possible further serious offences.

The investigation has identified a problem with the design of cell toilet doors which did not allow easy access in an emergency and also that an observation panel had been painted over. We also repeat a recommendation, made in a previous death in custody investigation at the prison, for Durham to improve its emergency procedures.

Of particular concern, however, in this case is how little appears to have been known about the man by staff at Durham. This was despite a number of efforts by the man's family, shortly before his death, to pass on their concerns about his mental health and the risk that he might harm himself. Unfortunately, these concerns were either not acted upon or, on the one occasion they were, not acted upon sufficiently. In the event, no one spoke to the man to check how he felt and therefore no consideration was given to using suicide and self-harm monitoring to help protect him from harm.

This final version of the report reflects both the man's family, NHS Durham and the National Offender Management Service (NOMS) response at the consultation stage.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **January 2013**

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SUMMARY

1. The man was arrested for a serious offence in March 2012 and remanded into custody at HMP Durham. This was his first time in prison. He said he had no past or current thoughts of self harm and no mental health, drug or alcohol issues.

2. The man felt low and was worried about his partner and family in his early days in custody, but appeared to settle. There were no significant entries in his case notes until 9 May, when he was re-arrested and questioned about further historical offences. He returned to prison on the same day. No assessment of his mood or health was completed when he came back to the prison.

3. In the week before the man's death, his family telephoned the prison three times to voice their concerns about him. The first two calls resulted in no action. During the third call, the man's sister told the head of the mental health team, she was concerned about the man's mental health and that he might "do something". A mental health referral was made, and wing staff were informed of the concerns. No one spoke to the man about this and suicide and self-harm support procedures were not put in place.

4. On the day the man died, he man went to morning workshop but returned to the wing almost straightaway saying he felt unwell. Staff noticed nothing unusual when he was locked back into his cell.

5. Around an hour later the mental health nurse went to the man's cell to conduct a mental health assessment. He saw that the cell was empty and toilet door was shut and locked. The door was jammed at the top with a towel and what appeared to be a belt. The nurse got no response from the man and was concerned for his safety.

6. After some initial difficulty in getting the toilet door open, the man was found to have hanged himself with a belt. Prison officers and the nurse quickly started cardiopulmonary resuscitation (CPR[1]) and were joined by another nurse and the doctor who bought emergency equipment. Despite their efforts, the man was declared dead by the prison doctor at 9.52am.

7. The report makes a number of recommendations. These relate to obtaining GP records on arrival, appropriate handling of information from families about risk, assessment of risk in changed circumstances, the personal officer scheme, the use of emergency codes and access to toilet areas in an emergency.

[1] Cardiopulmonary resuscitation (CPR) is a technique whereby oxygen is pumped around the body using a combination of chest compressions and rescue breaths.

THE INVESTIGATION PROCESS

8. Another PPO investigator visited Durham on 22 May 2012. She met relevant prison staff and visited the wing where the man died. She obtained copies of relevant prison and health records which she passed to investigator. Notices were posted informing staff and prisoners of the investigation and inviting them to contact the investigator.

9. The clinical reviewer carried out a review of the clinical care the man received at Durham, on behalf of NHS County Durham & Darlington. The investigator and clinical reviewer carried out a number of joint interviews with prison and healthcare staff in June 2012. This included interviewing the man's cell mate, who had transferred to HMP Holme House. The investigator gave the Governor verbal and written feedback.

10. The HM Coroner was informed of the investigation. A copy of this report will be sent to him to assist his enquiries.

11. One of the Ombudsman's family liaison officers (FLO) and the investigator visited the man's partner and also contacted other members of his family. She explained the investigation process and gave them the opportunity to raise any concerns or questions they wished to be addressed as part the investigation. The man's family raised the following concerns:

    - How did the man take his life and who found him?
    - They believed the contents of a letter found after the man's death mentioned suicide.
    - The man's family had raised concerns about his mental health but no extra monitoring seemed to take place
    - The man's two brothers visited him on the before his death. They were concerned about him being suicidal and said they told staff that their brother needed to see the mental healthcare team.
    - The following Monday. The man's brother called again and spoke to a woman at the visitors' centre who said she would pass on their concerns to the mental health team. .
    - The man's sister telephoned the prison on Thursday 17 May and spoke to the mental healthcare manager. She informed the mental healthcare manager of the man's previous episode of depression and that he had been on medication in the community. She also told him that she thought he was having suicidal thoughts. The mental healthcare manager promised that he would assess the man within 48 hrs.

12. The man's family received a copy of the draft report as part of the consultation period and raised issues that have been covered within the report. In particular, the man's brother provided the investigator with a copy of his BT telephone bill which showed the actual time that he had contacted the prison on 13 May 2012. This was at 6.34pm and the telephone call lasted for approximately seven minutes. The man's brother said he told the member of staff he was concerned about his brother and that he might be suicidal. The member of staff said that this information would be passed onto the mental healthcare team.

Unfortunately the investigator was unable to trace the person the man's brother spoke to. The man's family also pointed out inaccuracies of the man's date of birth, these have been amended where necessary.

HMP Durham

13. HMP Durham is a local prison serving the courts of Tyneside, Durham and Cumbria. It holds up to 1017 men in seven accommodation wings. Healthcare is provided by Care UK on behalf of NHS County Durham Primary Care Trust.

HM Chief Inspector of Prisons

14. The most recent inspection by HM Inspectorate of Prisons took place in October 2011. Inspectors found there were significant levels of self-harm with over 250 incidents in the nine months before the inspection. There was good strategic management of safer custody but the quality of suicide and self-harm documentation was variable. The report recommended that "The quality of the assessment, care in custody and teamwork (ACCT[2]) procedures, including case management arrangements, attendance at reviews and staff entries in documents, should be improved".

Independent Monitoring Board (IMB)

15. All prisons have an IMB of unpaid volunteers from the local community, who help to ensure that proper standards of care and decency are maintained. In its most recent annual report (1 November 2010 –31st October 2011). The Board identified no issues relevant to the circumstances of the man's death.

Previous Deaths at Durham

16. In the 24 months before the man's death there was one previous self inflicted death at HMP Durham. The circumstances of this case were not similar to those of the man. However during this period and following the natural cause death of a prisoner, a recommendation was made to addresses required improvements in Durham's emergency response procedures.

[2] The Assessment, Care in Custody and Teamwork (ACCT) system is a Prison Service-wide process for supporting and monitoring prisoners thought to be at risk of harming themselves

KEY EVENTS

17. In March 2012, the man was arrested and held in police custody until he appeared at court on 20 March, charged with two serious offences. He was remanded to prison custody. No concerns about his safety were identified during his time in police custody.

The man's arrival at HMP Durham

18. On arrival at Durham, the man went through the routine reception process. He was interviewed by prison staff who recorded a number of basic details, checked his property and told him about prison rules and procedures. Officer A and Nurse A carried out a cell sharing risk assessment (CSRA[3]) and concluded the man was suitable to share a cell.

19. Officer B interviewed the man. He noted that it was his first time in prison and he explained some prison rules to him. The man was offered a shower and hot drink and saw the reception Listener and Insider[4]. Basic details about the man's offence and his next of kin, which he listed as his partner, were noted.

20. Healthcare support worker (HCW) A carried out a health screen and recorded on SystmOne (prison electronic medical record) the man's basic observations (weight, pulse, height, blood pressure) and that he smoked 20 cigarettes a day. Immediately afterwards, Nurse A noted that he suffered from asthma and was prescribed inhalers. The man said he did not abuse alcohol and drugs and said he had never self-harmed or tried to commit suicide. Nurse A recorded that the man required no immediate healthcare intervention however she referred him to the prison doctor because of his history of asthma.

21. Prison Dr A examined the man and recorded on SystmOne that the man's asthma was well controlled by his current regime of inhalers. The doctor prescribed clenil modulate and salbutamol inhalers[5].

22. The man's first night induction continued throughout the evening on the first night wing, E wing. The man was issued with a PIN telephone number (prison system for making telephone calls) and allowed to make a telephone call. He was seen by a "Meet and Greet"[6] orderly on the wing. No problems were noted overnight.

23. The next morning, on 21 March, Officer B conducted an induction interview and noted the man's seemed low in mood. He said he was concerned about his partner and family. He had also heard his name and his alleged offence

[3] The CSRA process is designed to assess the risks posed by an individual to other prisoners.

[4] The Insiders scheme involves the training of selected prisoner volunteers to provide basic information and reassurance to prisoners new to prison. Listeners are trained by the Samaritans support prisoners who may be at risk of suicide and/or self-harm.

[5] Drugs used in the treatment of asthma.

[6] Trained prisoner who welcomes new prisoners onto the wings and helps them settle in.

mentioned on the nightly television news, and was concerned at how other prisoners might react to this.

24. Officer B said he had a long talk with the man about how he felt. He said he would not hurt himself as his family meant too much to him. He told Officer B that if his mood got any worse, he would not hesitate to ask staff for support. He was reminded of the support mechanisms that were available to him in the prison.

25. Afterwards Officer B discussed the man's situation with the wing senior officer (SO) A. Both agreed that opening prison suicide and self- harm procedures (Assessment Care in Custody Teamwork), was not necessary at that time. However, a written entry was made in the wing observation book and the man's history sheet on P-NOMIS (the prison computer record system) to ensure that wing staff were aware of the man's low mood.

26. The man's induction over the forthcoming days involved him seeing a range of agencies including drug and alcohol services, chaplaincy, and probation. He also had an "Immediate Needs Assessment" which recorded various details about his life style.

27. On Monday 26 March, the man moved to A wing and shared a cell with a prisoner. Throughout the rest of March and April, there are no reported concerns about the man.

28. On 30 April, Nurse B examined the man in the minor illness clinic. He had complained of being short of breath over the previous three weeks. The man was diagnosed with a chest infection and prescribed an antibiotic.

29. On the morning of 9 May, the man was re-arrested by the police and taken to Durham Police station. He was questioned about further past offences. The prison did not assess the man's mental well-being or risk level, when he returned to the prison around midday. There was no documented evidence on the man's medical record to suggest he was assessed when he came back through the prison reception.

30. The man's brother told the PPO family liaison officer that he visited the man in prison on Sunday 13 May. He was concerned about the man's mood and the type of things he was saying. This included the man saying that he would not be able to go to court as he felt suicidal. The man's brother said he telephoned the prison after his visit, around 5.00pm He said he spoke to a man on the main prison switchboard who noted his concerns and said they would be passed on to the prison healthcare department. The man's brother believed that the man needed to see someone from the mental health team. The investigator made enquiries about this but was unable to find any record that evidence, documented or otherwise that this call had been noted and acted on.

31. The next day, the man's brother telephoned the prison visitors' centre. The centre is outside the prison and is run by NEPACS, a voluntary sector organisation. The visitors' centre manager answered the telephone call. She

told the investigator that at the time of the call, the centre was closed and she was catching up on some paperwork. She had had no previous knowledge of the man or his family and did not make a record of her conversation with his brother. She told the investigator that the man's family had concerns about his well-being. His family thought he had lost weight and had not made much sense when they talked to him. She said she would pass on his brother's concerns to the mental health team. She took his contact details and telephoned him back the same day to say she had done this.

32. The man's brother confirmed that the visitors' centre manager did return his telephone call and said his concerns had been passed onto the prison mental health team. The investigator found no documented evidence relating to this contact in the man's medical or prison records.

33. One way for families who wish to raise a concern about a prisoner is to ring a dedicated hotline number (direct telephone number to the Safer Custody Office) and leave a message. The hotline number is advertised on posters in the visitors'' centre. The messages are picked up daily. The investigators' liaison officer checked the log book in the safer custody office for May 2012 and found that the hotline number had not been used to leave any messages about the man.

34. The man's brother provided the investigator with his telephone records. Although the times of calls are not shown on the telephone bill, it does record that four telephone calls were made to HMP Durham between 13 May and 14 May.

35. The man's partner told the investigator and the FLO that she had visited him on Wednesday 16 May. She noticed a change in his demeanour. He appeared distant and preoccupied with his own thoughts.

36. On Thursday 17 May, the mental health manager received a telephone call from the man's sister. She was concerned about her brother and said he had a history of depression. She was fearful he might do "something". She said he had passed her concerns on to an officer in the visits area, when she last saw her brother.

37. The mental health manager told the man's sister that he would make a referral for the man to be seen by a member of the mental health team. He checked SystmOne and there was no mention of the man having any acute mental health concerns. He completed a mental health referral form that day, noting that the man would be seen by a mental health worker within 48 hours. (This meant within two working days) This was passed on to the team secretary to organise an appointment. His medical record indicates that an appointment was arranged for Monday 21 May, with Nurse C.

38. The mental health manager contacted A wing and told Officer C about the concerns the man's sister had about her brother. He said his sister had told him he had a history of depression and she was concerned that he might be at risk of harming himself. The officer said that she wrote these concerns in the

wing observation book. She wrote that the man was to be seen by mental health tomorrow (Friday 18 May) and that staff were to monitor the man's mood. She said she passed on this information to wing staff including wing SO B. As the officer was not a landing officer, she had had no previous contact with the man. She did not speak to the man and was unaware if any other member of staff did so.

39. The investigator found no documented entries about the man in the wing observation book or P-Nomis by any other member of staff after Officer C's entry. SO B told the investigator that he did not recall a conversation with the officer about the man or ever speaking with the man.

40. With regards to Officer C noting that the man would be seen by mental health team on Friday 18 May, the mental healthcare manager said that he did not indicate when exactly the man would be seen. The Durham local policy states that all mental health referrals should be seen within 48 working hours. Should a patient present as acutely psychotic then arrangements would be made for them to be seen sooner. The prison does not have any mental health cover at weekends.

41. The horticultural workshop teacher told the investigator that the man had only attended two previous workshop classes. The first on Wednesday 16 May and the second the day after, so she did not know him well. The man seemed quiet and pleasant during the two classes. As he was new to the group, she did not find his quietness disconcerting as other members of the group, who were more talkative, had known each other longer.

42. Officer D was the man's personal officer. As part of Durham's local personal officer scheme, he was expected to be the man's first port of call if he had any concerns or issues, meet him regularly (every two weeks) and note the interaction in the P-NOMIS case notes. Officer D said he met and spoke with the man on about two or three occasions, although he did not record these. He described him as a "quite a quiet man" who was polite and caused no problems on the wing. Whenever asked, he said the man always said he was okay.

43. On the morning of Sunday 20 May the man made two telephone calls. The first was answered by his partner's daughter who passed the phone to her mother. The second call was made to his mother. Neither call suggested that the man was in any distress or likely to harm himself. His mother remarked that he sounded in a good mood.

Events on the morning on the day of the man's death

44. Around 8.00am, Officer E unlocked the man's cell as he was listed to attend the horticultural workshop. His cell mate was also going to work, but to a different workshop. The man's cell mate told the investigator that he had no concerns about the man's well-being. The officer told the investigator that the man was quiet and his usual self. While waiting to go to the workshop records show that the man made a telephone call at 8.05am to his partner's daughter that went straight to her voicemail. He did not leave a message.

45. Prisoners normally arrive for the horticultural workshop between 8.00am and 8.15am. The man was the second to last prisoner to arrive. The horticultural workshop teacher took the prisoners (approximately ten) to the gardens at the back of the prison. The man told her that he thought he was having a reaction to a Hepatitis B injection he told her he had had the day before. He said this was reacting with his asthma and he felt "really bad" and wanted to return to the wing. (According to the man's medical record, he received a Hepatitis injection on 24 April)

46. The horticultural workshop teacher noticed that he had sweat trickling down his forehead and his hands were shaking slightly. She was concerned that the man would not be physically able to work in the garden and took him back to Officer F, the movement control officer, who was nearby. She explained to Officer F that the man felt unwell and was returning to the wing. The horticultural workshop teacher said that the man was there no longer than about seven minutes.

47. Officer F told the investigator that he had no contact with the man, who had already started to walk back to the wing. Officer D was talking to another prisoner when the man arrived back on A wing. He asked the man why he had returned to which he just replied, "I've come back boss". Officer D said that a few prisoners had already returned that morning from other workshops and the man was one of around four or five prisoners who returned. The investigator was told that prisoners mainly returned because workshops were sometimes over subscribed.

48. On the way back to his cell on the second floor, the man made another telephone call, this time to his partner's telephone number (this was recorded on prison records as 8.36am). Again, this call went straight to voicemail and he did not leave a message. Officer G let the man back into his cell. He remembered nothing significant about the man's demeanour.

49. Nurse C, a mental health nurse went to A wing at 9.25am to conduct the man's mental health assessment. He opened the cell door, but could not see anyone. He noticed the toilet door was shut and called the man's name but got no reply. The nurse presumed the man was out and returned to the wing office to check. Officers H and I said the man should be in his cell, so the nurse returned to the cell.

50. Nurse C walked further into the cell and saw the toilet door was still shut. Noticing it was locked he knocked on the door but there was no response. At the top of the door he saw a towel rolled tightly with what appeared to be a belt going into the top of the door. It was pulled tight and the door appeared jammed. The door was a full size solid wood door going into a frame with only a slight gap at the top where the belt was strung through. He continued calling the man's name but there was still no answer. The nurse stepped out of the cell and shouted "staff" loudly to summon assistance fearing the man was possibly hanging behind the door. (When the investigator and clinical reviewer visited A wing during the course of the investigation, they noticed that the

surveillance glass cover for the toilet area of the man's cell had been painted over.)

51. Officers H and I arrived at the man's cell in seconds, followed closely by SO B. Officer H tried opening the toilet door but it was locked. The lock contained a coin slot which, if turned, should release the lock. The lock itself was a mortise type lock that entered into a lockable frame. However, the lock appeared jammed and the coin slot would not move. The two officers tried to kick the door open but were unable to do so. The SO radioed healthcare for urgent assistance and also requested staff from the works department to attend and bring tools to help open the door. The SO then also started trying to kick the door open. Officer D and the duty governor then arrived at the cell.

52. As they could not open the door, Officer H used his cut down tool to try and cut the belt. Officer I pulled the towel at the top of the door downwards as hard as he could so the cut down tool could be used. As the belt was cut, they heard a thump on the other side of the door. They believed the man had fallen to the floor. With his weight no longer anchoring the toilet door, the lock released itself. The officers went in and found the man unconscious with a belt around his neck. Officer I said it took around two minutes from him arriving at the cell to getting the door open.

53. Officer H used his cut down tool to remove the belt from the man's neck. Officer H, who is a first aid instructor, described the man as showing no signs of life, although his body was warm. Officers I and H started cardiopulmonary resuscitation (CPR).

54. Nurse D arrived at approximately 9.34am. He immediately requested further healthcare assistance, a defibrillator, oxygen, the prison doctor and an ambulance. It was noted in the prison incident log that an ambulance was called at 9.38am. The nurse checked the man but could find no signs of life. A defibrillator was attached to the man but it showed no heart activity and indicated CPR should continue. The nurse assisted the officers with CPR and after about five cycles of CPR, Nurse E and prison Dr B arrived with oxygen.

55. Prison Dr B continued to examine the man at intervals during the resuscitation attempts. However, despite efforts of the nurses and prison officers, at 9.52am the doctor pronounced the man's death, just as the paramedics arrived.

After the man's death

56. The man's sister had telephoned the prison early in the morning of the man's death, to speak to the mental healthcare manager. Nurse F took the call as the mental healthcare manager was unavailable. Within minutes of him being told the man had died, he was given the message that the man's sister had tried to contact him. He passed on this information to the duty governor. The mental healthcare manager said he assumed that, as he had spoken to the man's sister before the weekend, she had called back to check on how her brother was.

57. Two letters written by the man and addressed to his partner were discovered after his death. One was found in his cell and the other in the censor's department, before being was posted out of the prison. Once a prisoner puts post in the wing outbox, it normally leaves the prison within 24 hours. Normally only 5% of post is screened by prison staff.

58. In the first letter, the man said how much he loved his partner and the family. In the second letter, found in his cell, he said he had done nothing wrong, had not committed the alleged offence and was worried what he was putting his family through as he loved them. The man said he wanted “to stop the pain”.

59. Prison staff broke the news of the man’s death to his cell mate who was offered support if he needed it. Prisoners on the wing were also offered support.

60. A hot debrief meeting was held at 10.05am for prison and nursing staff that had attended the man’s cell. The prison’s Care and Support team were present to ensure staff were offered support. The mental healthcare manager also attended the meeting to support staff, particularly Nurse C.

Contact with the man’s family

61. Officer J was appointed as the family liaison officer (FLO) at about 9.45am. She and a chaplain drove to the man’s partner’s house, but on the way they were contacted by the police liaison officer (PLO) who said his partner had moved and they were given a new address. They arrived at 1.30pm. At first no one was in. After waiting for about 45 minutes, a man arrived and said the man’s partner was unknown to him and did not live at the address.

62. They phoned Carlisle police who were unable to provide any contact details. The FLO and chaplain decided to return to the original address they had been given. They got there at about 2.30pm, but the occupant of the property said that the man’s partner did not live there.

63. They decided to visit the man’s partner’s daughter’s address and arrived there at around 3.00pm. The man’s partner answered the door and the FLO and chaplain broke the news of the man’s death to her. She in turn contacted the man’s other family members.

64. Shortly after this the duty governor received upset telephone calls from the man’s sister and daughter. When the FLO arrived back at Durham, she contacted them and explained her role and what would happen next. The man’s partner’s daughter said her aunt (the man’s sister) would be the main point of contact for the family to organise the funeral.

65. Over the next few days, the FLO kept regular contact with the man’s family. Funeral arrangements were made and, in line with national guidance, financial assistance was offered. The man’s property was returned to his family. A prison memorial service was also held for the man. Arrangements were made for the man’s partner to visit the prison.

Post- mortem report

66. At the time of issuing the draft report, we are still awaiting the results of the post-mortem examination.

ISSUES

Clinical care

Reception screening

67. The man's sister told the mental healthcare manager that the man had previously suffered from depression for which he had been prescribed medication. The man did not disclose this information during his reception health screen. The only health matter he raised was that he was asthmatic. Healthcare staff did not contact his community GP to provide a summary of his medical history as they did not believe he had any immediate health needs.

68. Although the man required no immediate healthcare intervention, asthma is a long term condition. As part of his reception health screening, the man gave consent for his GP to be contacted to obtain up to date briefing on his medical history. We consider that it is good practice to obtain GP records in all cases but it is particularly important when a prisoner had a chronic condition such as asthma, to allow effective continuity of care.

69. Prison Service Order (PSO) 3030, Continuity of Healthcare for Prisoners states that when a new prisoner arrives,

> "…Efforts should be made to retrieve any information required from the prisoner's GP or other relevant service he/she has recently been in contact with. The prisoner's explicit consent should be obtained before doing this…"

70. We make the following recommendation:

The Head of Healthcare should ensure that community medical records are obtained as part of the reception health screening process, particularly when a prisoner has a pre-existing condition.

Secondary health screening

71. The man's healthcare record indicates that he did not have a secondary health screen after his reception because he was not in his cell when they visited him to conduct it on 26 March. No further reference is made to the man being offered or having received a secondary health screen and therefore it has to be assumed that he did not have one. Prison Service Order 3050 (Continuity of Healthcare for Prisoners) states that,

> "In the week following first reception, every prisoner must be offered a general health assessment. This assessment is equivalent to a primary care assessment when registering with a new practice in the community."

72. Such an assessment provides an opportunity to gather further medical information, check how the prisoner is settling in, and for some health education

and promotion. This would have been a further opportunity for the man to speak to healthcare staff about himself and his previous medical history. We make the following recommendation:

The Head of Healthcare should ensure that all prisoners are offered secondary heath screening within the first 5 days of reception. Should a prisoner decline this screening, healthcare should note this decline within the clinical system.

The man's risk of self-harm

73. It was recognised that the man's mood was low in his early days at Durham. The day after his arrival an officer spoke to him at length and explained the support available. The staff assessment at that stage was that there was no need to open suicide and self-harm monitoring procedures (ACCT). There is no record of anyone else in the prison speaking to him at any length after this point.

74. The man was arrested and taken to the Durham Police station for questioning about further serious offences, twelve days before his death. There is no record of the man's demeanour at that time but this was his first time in prison, he was on remand for a serious offence and he was arrested again and questioned about further serious offences. We believe it would be reasonable to presume that this would have caused the man some anxiety

75. Prison Service Instruction 64/2011 about safer custody, highlights that a prisoner's risk (or likelihood) of violence, self-harm and/or suicide may increase in certain circumstances and notes that a prisoner facing further charges is a known trigger which may increase risk of self-harm, suicide or violence.

76. Further guidance in PSO 3050 states:

> "Events that require a prisoner to leave the prison and pass back through prison reception [as the man did], can have significant impact on the health of a prisoner."

77. The PSO includes events such as attending court, sentencing at court and being questioned by the police and notes that prisons must have protocols in place for screening such prisoners for any potential healthcare, or suicide/self-harm issues. There is no evidence that the man received any further screening when he arrived back at the prison on 9 May, after being questioned by the police.

The Governor and Head of Healthcare should ensure that all prisoners returning to the prison after events which could involve a change in status, including court appearances and being questioned by the police, should be assessed for potential health or suicide and self-harm issues.

Personal Officer Scheme

78. The man had been allocated a personal officer. The officer said he had spoken to the man two or three times and he had said he was okay. However, there are no personal officer entries in the P-NOMIS case notes. It is not therefore apparent that anyone at Durham had made significant effort to get to know the man. It was his first time in prison and by the time of his death he had only been in custody for two months. The lack of planned and regular meetings with a personal officer meant that there were few opportunities for anyone to interact individually with the man and be alert to any concerns or thoughts that he might have had about harming himself.

79. Having a nominated personal officer or other key worker is a fundamental part of caring for prisoners and prisons should provide properly functioning arrangements. Personal officers should make active efforts to get to know their allocated prisoners and their circumstances and make regular entries in prisoners' case notes to support this. We note that the October 2011 inspection of Durham found that most case notes demonstrated little and superficial contact with personal officers and that fewer than half of the prisoners they surveyed were aware they had personal officers. Inspectors said that many prisoners reported a disinterested attitude from staff. The Governor wrote to the investigator in July 2012 to say that he was taking immediate action to ensure that staff were made aware of the importance of accurate record keeping. We welcome this reminder but we do not consider this a matter of record keeping alone. Records need to reflect active and supportive relationships.

    The Governor should ensure that officers have meaningful contact with every prisoner, through an effective personal officer scheme which ensures that officers get to know prisoners and identify their needs, supported by regular case history notes.

Concerns raised by the man's family

80. The man's family expressed their concern to the prison about the man's state of mind at least three times shortly before his death. The man's brother's telephone records show that calls were made to Durham on 13 May, which he said followed his visit that day. He told investigators that he spoke to a man on the prison switch board about his concerns about the man's mental health. The investigator was unable to find any record that these concerns were documented and passed on.

81. The next day, 14 May, the man's brother telephoned the prison again and he spoke to the manager of the visitors' centre. This was confirmed by the manager who said she passed on the man's brother's concerns to the healthcare department. Again, the investigator was unable to find any documented evidence that these concerns were noted in any of the man's records.

82. On Thursday 17 May, four days before his death, the man's sister spoke to the mental healthcare manager. She mentioned in her telephone call that she had also expressed concerns in person to an officer in the visits area. The mental healthcare manager believed that from what the man's sister had said, she considered he was at risk of harming himself and made a mental health referral for the man to be seen within 48 working hours. The man was to be seen the following Monday. The mental healthcare manager said that, had the man demonstrated current acute mental health problems (witnessed in person or recorded on his medical record), arrangements would have been made for an urgent referral. The man's medical record contained no reference to any current concerns about his mental health.

83. The mental healthcare manager passed on the family's concerns about the man to his wing. Although this was documented in the wing observation book, there was no explicit reference to concern that the man was at risk of self-harm. No one went to speak to the man to see how he was. The officer who took the message said she had only limited knowledge of him and passed this information on to the senior officer. The senior officer said that he had never spoken to the man during his stay. None of the staff involved, mental healthcare manager nor the officer and senior officer on his wing appear to have considered opening an ACCT document so that the man could be assessed and monitored as a risk of suicide and self-harm.

84. There were at least three occasions when important information from the man's family reflecting serious concern about his well-being was relayed to the prison. Only the last of these resulted in any action being taken in the form of a referral for a mental health assessment. We consider that this was not enough. It should at least have prompted someone to go to see and speak to the man. His family, who were best placed to know and understand him were very concerned about what he might do but there was no consideration about whether the man should have been made subject to suicide and self-harm monitoring. Wing staff, who should have been best placed to make an assessment did not act on the information and this was a serious omission.

85. The lack of any record of the man's family's previous attempts to alert the prison is also a significant concern. PSI 64/2011 clearly states:

> "All staff who receive information, including from concerned family members, or observe changes in a prisoner's behaviour which indicates a change in the risk they pose to themselves, to others and/or from others must communicate their concerns immediately to the Residential, Daily or Night Operational Manager, and/or consider opening an ACCT Plan and make a record in an appropriate source e.g. observation book, NOMIS, Security Information Report, ACCT Plan"
>
> "Any member of staff who receives information, including that from family members or external agencies, or observes behaviour which may indicate a risk of suicide/self-harm must open an ACCT by completing the Concern and Keep Safe form."
>
> .

"Information may become available throughout a prisoner's time in custody which may affect their risk of harm to self, others and/or from others. It is vital that this information is recorded and shared to inform proper decision making."

86. We make the following recommendation:

The Governor should ensure that any concern about a prisoner from families and other external sources is accurately recorded, acted on quickly and an ACCT opened when there is an indication of a risk of suicide or self-harm.

The emergency response

87. When Nurse C discovered there was a possibility that the man had harmed himself behind the toilet door, the response by prison staff was quick and professional. Appropriate attempts at CPR were made.

88. Although the prison has an emergency code system this was not used. Durham's local policy requires that, if a prisoner is found unconscious or there is no response, a code black should be called. It says that the first on scene should do this. Use of an emergency code enables those attending to be better prepared for the type of situation they are attending and inform what emergency equipment might be needed. The first nurse that arrived did not bring emergency equipment with him.

89. In an investigation into another death at Durham in May 2011, we recommended that the Governor should ensure staff implement the emergency actions set out in Durham's local policies on summoning medical Help. This was not effective in this case. Nor was an ambulance called until 9.38am, approximately 10 minutes after the urgent assistance was first called. Effective code systems highlight the nature of the emergency and allow the communications officer to call an ambulance immediately if a particular code is used.

The Governor should ensure an effective emergency code system is implemented, which includes a requirement to phone immediately for an ambulance in appropriate situations.

90. Initially, staff experienced great difficulties gaining access to the toilet area because of the solid door and lock. The external surveillance glass had been painted over so it was not possible to see the man and assess the situation.

91. The difficulty of accessing the toilet area of the cell in such a situation was acknowledged by the Governor. We understand that remedial work to address the problem of the design of the toilet door is already underway. Nonetheless, we make the following recommendation:

The Governor should ensure that observation panels into cell toilet areas are useable and that it is possible to get rapid access in an emergency.

CONCLUSION

92. This was the man's first time in prison custody. He was arrested on a serious charge and was still on remand at the time of his death. He had been questioned about further serious offences which would have increased his anxiety but no one assessed his risk when he returned to the prison.

93. Although prison staff apparently did not identify any concerns about the man, it does not appear that anyone made any significant effort to get to know him. His family, who were best placed to understand him, alerted the prison on a number of occasions in May 2012 about their concerns regarding his mental state and potential risk of suicide or self-harm. These concerns were either not acted on or in the one occasion they were, the actions taken were insufficient. No-one considered the need for suicide and self-harm monitoring.

94. The heavy wooden door prevented easy access to the toilet area of the cell, where the man was found and staff could not see into the area as the observation panel had been painted over. Once entry was gained the man could not be resuscitated despite attempts from trained staff to save his life.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that community medical records are obtained as part of the reception health screening process, particularly when a prisoner has a pre-existing condition.

   The National Offender Management Service accepted this recommendation, writing

   "A protocol is in place for requesting GP medical records from community teams with a trigger point for clinicians and administration team for requesting records. Figures can be retrieved from the clinical IT system. The healthcare team follow up the requests at 48hrs & 72 hrs to ensure that community comply with our request.

   HMP Durham Care UK healthcare administration team have good relationships with many community practices, however there is no formal agreement commissioned that requires them to respond to our requests as provider.

   HMPS Resettlement Pathway will as part of their innovation work be developing closer working links with external agencies and Care UK will continue to work in partnership with HMPS to ensure seamless care in and out of custody."

2. The Head of Healthcare should ensure that all prisoners are offered secondary heath screening within the first 5 days of reception. Should a prisoner decline this screening, healthcare should note this decline within the clinical system.

   The National Offender Management Service accepted this recommendation, writing

   "All prisoners arriving at HMP Durham are offered secondary health screenings within the agreed timescales; this can be evidenced via our clinical IT system. However such screenings are not compulsory and unfortunately a high percentage of our prisoner/patients choose not to attend. It is highly likely this is due to a significant number of prisoners who return to HMP Durham on a revolving door basis and having attended the screening previously does not feel inclined to attend again.

   Healthcare staff will continue to encourage prisoners to attend secondary health screenings. HMPS also intend to develop an area of the prison, which will enable all new prisoners during their first week in prison, to access a one stop approach to all the relevant agencies. It is hoped that this approach will see a significant improvement in prisoner engagement in the reception process across all agencies."

3. The Governor and Head of Healthcare should ensure that all prisoners returning to the prison after events which could involve a change in status, including court appearances and being questioned by the police, should be assessed for potential health or suicide and self-harm issues.

The National Offender Management Service accepted this recommendation, writing

"All prisoners returning to the prison after events which could involve a change in status, including court appearances and being questioned by the police, are seen by a nurse & reception staff in the reception area to check for potential health or suicide and self-harm issues and update records."

4. The Governor should ensure that officers have meaningful contact with every prisoner, through an effective personal officer scheme which ensures that officers get to know prisoners and identify their needs, supported by regular case history notes.

The National Offender Management Service accepted this recommendation, writing

"Each Senior Officer and Officer working in the Residential function has an objective concerning the personal officer scheme in their 2012/2013 Staff Performance and Development Record (SPDR).

Senior Officer SPDR objective: Example - ***PERSONAL OFFICER***
Ensure a proactive personal officer scheme is maintained across your area of responsibility and that staff are fully aware its importance in creating positive relationships between them and their prisoners. Promote and encourage positive and productive interaction between your staff and the prisoners they are responsible for ensuring that at least 2, quality CNOMIS entries are made on a monthly basis by staff and that you complete a full management check on a bi-monthly basis."

5. The Governor should ensure that any concern about a prisoner from families and other external sources is accurately recorded, acted on quickly and an ACCT opened when there is an indication of a risk of suicide or self-harm.

The National Offender Management Service accepted this recommendation, writing

"All information indicating the risk of suicide or self harm from any source is acted upon and if after assessment it is thought necessary an ACCT is opened.

The Prisoner Escort Record (PER) highlight any concerns as do the escorting staff and provide information regarding concerns of this nature.

Visits & Visitors Centre - via posters providing contact details and direct contact with staff during social visits.

Fax – direct to the safer custody office and via e-mail also to the offender management unit. Direct phone line to the Safer Custody Office.

Legal representatives via direct contact during legal visits or telephone and/or correspondence."

6. The Governor should ensure an effective emergency code system is implemented, which includes a requirement to phone immediately for an ambulance in appropriate situations.

The National Offender Management Service accepted this recommendation, writing

"There are procedures (Action Sheet) for emergency access for paramedics and ambulance services and they are located in the Control Room and the Gate lodge. HMP Durham will do everything possible to preserve life and we will ensure the emergency services are given all the assistance to perform their role whilst attending the establishment.

A quick time learning bulletin **Responding to Medical Emergencies** has been circulated in October 2012 to all prisons from National Safer Custody Managers & Learning Team Offender Safety, Rights and Responsibilities Group. A Governors Notice to staff will be circulated to remind staff of the procedures."

7. The Governor should ensure that observation panels into cell toilet areas are useable and that it is possible to get rapid access in an emergency.

The National Offender Management Service accepted this recommendation, writing

"The observation panels into the toilet areas have been checked by the works department and are useable.

The works department are reducing the size of all doors into cell toilet areas. Work is ongoing to reduce all doors/panels by 3 inches at both the top and bottom on all cells that have them to ensure that it cannot be wedged closed and to provide easier access during emergencies. This work is expected to be complete by mid December 2012."