# Investigation into the circumstances surrounding the death of a man at HMP & YOI Holme House in March 2011

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

**November 2011**

This is the investigation into the circumstances surrounding the death of a man who was found hanging by his cellmate early in the morning on a day in March 2011. He was 40 years old. I offer my sincere sympathy and condolences to the man's family and friends for their loss.

The investigation was carried out by one of my colleagues. A clinical review of the man's healthcare was undertaken by a clinical reviewer on behalf of the North Tees Primary Care Trust. I am grateful for his review. I would also like to thank the Governor of Holme House and his staff for their co-operation and assistance.

In 2005, the man was sentenced to an indeterminate sentence for public protection. He was released on 23 February 2011 and was staying in a probation approved premises (hostel) in Middlesbrough when he was recalled to prison on 7 March. He spent a week in prison and gave staff no indication that he might be at risk of harming himself. He took his life early in the morning on a day in March.

Prisoners who have been recalled to prison while released on licence are at a higher risk of self-harm and suicide. I have noted that I believe the prison could be more pro-active in managing this risk. However, I do not criticise the prison in the case of this man, as my investigator found no overt signs specific to him that he was at risk.

I make two recommendations regarding mental health assessments and safeguarding prisoners who have been recalled to prison. I am disappointed to be repeating a recommendation regarding mental health assessments. I also include two areas that I believe the Governor will wish to consider further: information sharing during emergencies and safeguarding prisoners recalled due to breaching their licence conditions.

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.

**Thea Walton**
**Acting Deputy Ombudsman** **November 2011**

**CONTENTS**

## SUMMARY

1. The man was sentenced to an indeterminate sentence for public protection in 2005. He was released on 23 February 2011, subject to the conditions of his licence. He breached the terms of his licence and was recalled to prison on 7 March.

2. Holme House staff assessed the man upon his arrival and no concerns were noted. He went to the induction unit where he shared a cell with another prisoner.

3. Over the next five days, the man completed his induction course and did not cause any concerns for staff. He spoke to staff, but the conversations he had with officers were generally about routine matters, and staff did not believe him to be at risk of harming himself.

4. The man's cellmate was moved to a different part of the prison on 12 March, so a different prisoner was moved into his cell. This prisoner also told the investigator that he had no idea that the man might harm himself.

5. At approximately 1.15am on a morning in March, the man's cellmate got up to use the toilet, and realised that the man was hanging from a ligature attached to the toilet door. He raised the alarm and staff responded. However, attempts to resuscitate him were not successful and he was pronounced dead at 1.50am.

6. The prison told the man's family of his death and contributed to the cost of the funeral.

7. Although I do not believe Holme House missed signs that the man might have harmed himself, I make two recommendations regarding mental health assessments and support for licence recall prisoners.

## THE INVESTIGATION PROCESS

8. The investigation was carried out by one of my colleagues. He contacted HMP Holme House and arranged to visit the prison to open the investigation. My colleague visited Holme House on 17 March 2011, and viewed the man's cell on Houseblock 4. He reviewed the paperwork and met staff involved in the care of the man. Notices of the investigation were sent to Holme House, inviting staff and prisoners to contact the investigator with any relevant information. No-one came forward in response to the notices.

9. My colleague asked North Tees Primary Care Trust (PCT) to undertake a review into the clinical care received by the man at Holme House. A clinical reviewer was commissioned to undertake this review on their behalf.

10. One of my family liaison officers contacted the man's mother to explain the investigation and provide her with an opportunity to raise any concerns. They did not raise any concerns. I trust that this report provides more information for the man's family.

11. My colleague travelled to Holme House to interview prison and healthcare staff on 18 May 2011. The clinical reviewer was provided with the transcript of the interview with the member of nursing staff. He also spoke with the man's offender management to clarify details of his recall to prison.

12. My colleague provided written feedback to the Governor, following the interviews to inform him of the preliminary findings of the investigation.

## HMP & YOI HOLME HOUSE

13. Holme House is purpose built category B prison, which opened in May 1992. Prison Service Order (PSO) 0900 (Categorisation and Allocation) explains the reason for categorising prisoners:

> "Prisoners must be categorised objectively according to the likelihood that they will seek to escape and the risk that they would pose should they do so."

14. Category B prisoners are defined in the PSO as:

> "Prisoners for whom the very highest conditions of security are not necessary, but for whom escape must be made very difficult."

15. Its population is primarily drawn from Tees Valley, South West Durham, East Durham and North Yorkshire. It has an operational capacity of 994. The healthcare department has room for 24 prisoners

### Release on licence

16. Prisoners can be released on licence before the expiry of their sentence. In this situation, they are supervised by the Probation Service. They can be recalled to custody at any point until the expiry of their licence if their behaviour gives grounds for concern.

### Independent Monitoring Board (IMB)

17. Each prison is monitored by an Independent Monitoring Board (IMB), members of which are drawn from the local community. They have full access to prisoners and every part of the establishment. The last available report dates from 2009. In the report the Independent Monitoring Board (IMB) stated that most prisoners considered Holme House to be a safe prison, and noted that suicide prevention training has been extended to all staff who come into contact with prisoners.

### HM Chief Inspector of Prisons

18. HM Chief Inspector of Prisons conducted a full unannounced inspection of Holme House from 19 to 23 July 2010. It said that "the prison delivered reasonably good outcomes for prisoners in all areas." The report noted that "the self-harm and suicide strategy was cohesive and comprehensive", although it said there were insufficient listeners.

### Previous deaths at Holme House

19. Holme House experienced their last self-inflicted death in July 2010. That prisoner also died in his first week in custody after staff assessed that he was not at risk of harming himself. In that report, a recommendation was made regarding the need for mental health assessments for prisoners with a history

of mental health problems.  I have made the same recommendation again in this report.

## KEY EVENTS

20. The man was born in October 1970. He was arrested and sentenced to an indeterminate sentence for public protection in 2005. (An indeterminate sentence is a life sentence, where a minimum tariff is given, but the prisoner must still satisfy the Parole Board that he is fit for release and does not pose any threat to the community.) The man was not deemed at be at risk to himself during his time in custody at North Sea Camp, his last prison before release. During his time at North Sea Camp, it was recorded by healthcare staff that the man had a history of depressive illness and substance misuse. It was also noted that he had harmed himself outside of prison, but had not done so while in custody.

21. The man was released on 23 February 2011 and was sent to stay in a probation approved premises in Middlesbrough. He breached the terms of his licence by not returning to the hostel by the curfew deadline, and was subsequently arrested. He returned to HMP Holme House on 7 March 2011.

22. The Person Escort Record (PER) is a document, individual to each prisoner, agreed by all the agencies involved in the management of the transfer of prisoners to record the external movements of the prisoner between those different agencies. In the case of this man, the PER that accompanied him to Holme House made reference to warnings about violence and weapons dating back to 2005, but there was no indication on it that he was at risk of harming himself.

23. When prisoners arrive at a new prison they go through the reception process. A number of interviews are undertaken to assess their physical and mental well-being, and initial needs. A cell sharing risk assessment is carried out to establish the level of risk a prisoner presents to a cellmate. The man told an officer that he had no concerns about sharing a cell, and he had done so on previous occasions. No self-harm concerns were noted and he was judged to be at low risk of harming a cellmate. The officer said that, although he could not remember the conversation, he expected he would have known that the man was a licence recall prisoner.

24. The officer also undertook an induction interview with the man to determine if he had any immediate needs to be addressed. During this conversation, the man confirmed that he had no immediate concerns, and had no current issues regarding drugs or alcohol that required treatment. There is no indication that they specifically discussed the man's licence recall during this meeting.

25. A first reception healthscreen is conducted with all prisoners when they enter a prison. A nurse spoke to the man and noted that he was a smoker who did not wish to stop smoking, had no thoughts of harming himself and had no physical or mental health concerns. She assessed him as needing no immediate action and as being fit for a cell on a regular houseblock. This was the last time the man saw a member of the healthcare team before he was found on the day of his death.

26. The man was assigned to cell 01-08 in C wing on houseblock 4 at about 6.00pm. This was in the induction wing, and prisoners could expect to stay there for between one and ten days. Cell 01-08 is a double cell, and the man had a cellmate. The cell has its own toilet behind a privacy door.

27. The following day, the man and his cellmate undertook their day one induction which involved being introduced to the prison processes and meeting various agencies operating the prison. Over the next few days the man's induction continued with an introduction to the gym and an educational needs assessment.

28. The man's cellmate changed on 12 March as the cellmate moved to houseblock 1 as a sentenced prisoner. Another cellmate moved into his cell. The new cellmate told my investigator that, although the man had seemed a bit down, he neither said nor did anything that suggested to him that he might harm himself.

29. One of the man's personal officers told my investigator that he spoke to him over the weekend preceding his death. The officer said that the conversations concerned issues about the regime, such as the time for exercise, and did not contain anything of significance. There was nothing in their conversations that concerned the officer and he explained that he would have made a note of anything that did concern him. He did not indicate that they discussed the man's licence recall at any point. He recalled that the man seemed a quiet man, but was not afraid to ask questions of the staff.

30. My investigator spoke to the man's offender manager in the community who confirmed that she spoke to him on the telephone a few days after he was recalled. She said that he was aware of the reason for being recalled. The man would have been subject to the recall parole process, meaning that the reason for his recall would be assessed to see if it was reasonable.

31. A few days after the man returned to prison, an officer was appointed to speak to the man regarding his recall. The officer was required to meet with him within nine days. She did not meet with him before he died, but this was within the timescales. I also understand that the offender manager in the community is responsible for producing a recall file in approximately 14 days. The offender manager explained that this had not been completed by the time of his death. Due to this, I understand that the man would not have known how long he would have been likely to serve in prison.

32. The man's cellmate said that he did not notice any change in him in the day before his death although he told the investigator of a conversation they had which seemed significant, with the benefit of hindsight. The man asked his cellmate if he thought he would go to heaven or hell when died. The man said he thought he would go to hell but, as he laughed when he said it, his cellmate was not overly concerned. During the evening before his death, the man's cellmate said he was very quiet and asked for some tobacco so he could make two cigarettes during the night without waking him. The cellmate

said that, in retrospect, this seemed odd as he never asked for it before, and had not previously smoked in the night.

33. At approximately 1.15am the following morning, the man's cellmate got out of bed to use the toilet. He noticed that the man's bed had not been slept in and, when he tried the toilet door, was unable to gain entry. He pressed the cell bell to raise the alarm. An officer went to the cell and his cellmate explained that he thought the man had hung himself in the toilet area. The officer immediately radioed through a code blue message at approximately 1.18am (this indicates an emergency related to breathing). He then ran to alert an Operational Support Grade (OSG) and a nurse. When they arrived at the cell, they broke the seal on the cell key pouch and opened the door. (Officers do not carry keys at night but do carry a key to enter a cell which is sealed in a pouch.) They managed to open the toilet door and the officer cut the ligature with his anti-ligature knife. The ligature was made from a bed sheet. They lay the man on the floor and the nurse began cardio-pulmonary resuscitation (CPR). The officer took the man's cellmate out of the cell.

34. The initial code blue alert referred to houseblock 2. A nurse, the night orderly officer and three other officers all headed there. The nurse carried the emergency response bag (this contains oxygen, masks and dressings). They were met at the gate of houseblock two by an OSG who told them that the emergency was in houseblock 4. The location of the emergency was also clarified with the communications room. They reached the man's cell at approximately 1.22am. (The nurse told my investigator that the wrong location meant they took approximately an extra minute to reach the right location.) The nurse asked for an ambulance to be called and for a defibrillator. (Defibrillators deliver a brief electric shock to the heart, which enables the heart's natural pacemaker to regain control and establish a normal heart rhythm.) One of the assistant night orderly officers got the defibrillator from the wing office. The night orderly officer asked the communications room to call for an ambulance. He also told one of the officers to take the man's cellmate to the TV room, provide him with a cup of tea and to keep an eye on him.

35. The defibrillator was used but it instructed staff not to shock the man as there was no electrical activity in his heart. The nurse noted in his statement that the man had no cardiac or respiratory output during this time, and his pupils were fixed and dilated. The paramedics arrived at approximately 1.35am and injected adrenaline and atropine (drugs used during resuscitation attempts) into a cannula inserted into the man by the nurse. (A cannula is a tube inserted into the body to aid the administration of drugs or fluids.) The paramedics applied their own defibrillator to the man. This confirmed that there was no electrical activity in his heart.

36. The nurse explained that, following these checks, the night orderly officer asked if there were clinical signs of life. The paramedics said that there were not. At approximately 1.50am, the paramedics pronounced the man dead.

## Liaison with the man's family

37. An officer was contacted at home and asked to report to the prison to act as the prison's family liaison officer. He arrived at the prison at approximately 5.00am where he collated the information relating to the man's next of kin. At 7.00am, the family liaison officer and deputy governor left the prison to visit the man's mother. They arrived at her house at 7.30am but were unable to get a response. They returned to the prison and contacted the Coroner's office to ensure that the family would not be contacted until the prison had broken the news.

38. At 10.00am, two officers went back to the man's mother's home and broke the news to her. The man's mother contacted other members of her family and they came to join her. One of the officers offered a visit into the prison, and offered to return her son's clothing – but the family declined the offers. She also explained that the prison would contribute to the costs of the funeral.

39. An officer returned to the man's mother the following day, to return his driving licence and passport. His mother agreed that the prison could provide a floral tribute for the funeral, but asked that no staff attended.

## Care for staff and prisoners

40. A hot debrief was held at 7.00am on the morning of the man's death. (This is a meeting of all the staff who were involved in finding and attempting to resuscitate the prisoner. The meeting should focus on reassurance, information sharing and how staff can support each other.) Unfortunately, the nurse who had responded to the code blue alert was not invited and consequently did not attend this debrief. The care team was deployed to ensure that staff had the support they required. A critical incident debrief was undertaken on 1 April.

41. Following the finding of the man, his cellmate was taken to the healthcare centre and assessed to ensure that he coped with the finding of the man. All prisoners subject to suicide and self-harm monitoring procedures on houseblock 4 were reviewed to ensure that they were supported following the death of the man.

## ISSUES

### Clinical care

42. A clinical review of the man's medical care was undertaken by a clinical reviewer. The man had very little contact with the medical services during his week in Holme House. The clinical reviewer summarises the man's account of his health on his return to prison as follows:

> "The clinical record identifies that [the man] had a history of depressive illness which was previously treated by mirtazapine (a medicine used primarily for the treatment of depression). It seems that he had not taken any antidepressant medication for some two years.
> [The man] reported to healthcare staff that he had tried to harm himself (outside prison); he had previously cut his wrist when drunk. However, he had not tried to harm himself whilst in custody. He had previously used drugs, namely cannabis, speed, cocaine and had injected anabolic steroids."

*Mental health*

43. The clinical reviewer points out the specific clinical risk factors the man had, such as his mental health history:

> "[The man] had a history of depressive illness previously treated by antidepressant medication which he no longer was taking whilst in prison. He had a history of substance misuse, a history of violence and was 40 years old and still serving his first and only prison sentence (albeit he had served around 5 years of that original sentence). These are indicators of risk for a propensity to commit suicide. The Clinical Reviewer recognises and acknowledges that these risk indicators are invariably commonplace amongst many serving prisoners. Although to have not identified these as specific risk factors from the reception healthscreen a week before his death could be considered a missed opportunity to have made that assessment of risk and a plan to mitigate that risk."

44. A nurse considered the man's mental health during the first reception healthscreen and no concerns were recorded. As the clinical reviewer notes, this explains why he was not referred to the mental health team. However, the clinical reviewer suggests that a referral to the mental health team might have been appropriate given the man's history of depression:

> " … the Clinical Reviewer opines that any prisoner with a known history of mental disorder, especially of a depressive nature, should be subject to adequate mental health screening either as part of the reception healthscreen process or, if staff do not possess suitable skills, then carried out by the mental health team as soon as practicably possible following reception. Where specific risk factors are identified from

> mental health screening then further and in-depth mental health risk assessment should follow. This did not happen for [this man]."

45. I agree that a mental health assessment would have given staff another opportunity to speak to the man, and decide whether he needed any further support. However, it must be acknowledged that even if this had happened, the referral could have taken up to a few weeks. The man's presentation was unlikely to have prompted an urgent referral and he may therefore have died before any assessment took place. The report into the last self-inflicted death at Holme House also raised concerns about prisoners with a history of mental health problems not being referred for mental health assessments. I consider that, given the circumstances of the man's death, it is necessary for me to make the same recommendation again:

**The Head of Healthcare should remind staff that when a prisoner discloses previous mental health problems during the reception process, this should be followed up with a referral to the mental health services, in line with the prison's operation policy guidelines.**

*The attempted resuscitation of the man*

46. The clinical reviewer considered the prison's reaction to discovery of the man. He writes:

> "The Clinical Reviewer has no specific observations, comments, criticisms or concerns to make about how healthcare and custodial staff responded to when [the man] was discovered hanging in his cell and their subsequent attempt at emergency life saving. This appears to have been managed effectively and appropriately with all staff trying their best to help [the man], albeit sadly he died. Staff witness statements, the clinical record and interview transcript provide a consistent confirmation of the effectiveness and appropriateness of the operational and clinical response."

47. Overall, I agree with the clinical reviewer's assessment regarding the discovery and attempted resuscitation of the man. However, it is disappointing that initially the wrong location of the emergency was given to staff by the communications room. This cost staff time in reaching the man's cell. Although I acknowledge that a nurse based on houseblock 4 responded to the emergency, and the delay was not a long one, any delay could have important consequences in future emergency situations. I am sure the Governor will wish to remind staff of the importance of vital information being clearly relayed to the appropriate staff during any emergency situation.

**Licence recall**

48. Licence recall prisoners are considered to be at a higher risk of harming themselves due to uncertainty regarding their custodial prospects. It is not immediately clear how long they may serve in prison, and this can be a source of distress to some prisoners. Prisoners who have been recalled must

have their recall paperwork given to them to explain why they have been recalled, and offer them the chance to appeal against the decision to recall them. I understand that the man had not received any recall paperwork at the time of his death, and would not have known how much longer he may have had to serve.

49. The man was dealing with a number of issues in his life. He had been recalled to prison, had a propensity to depression and potentially faced another substantial period in custody. I appreciate the context that staff made their decisions in, and cannot apply hindsight. Due to this, given the man's decision not to tell staff of his state of mind and his apparent ability to cope in custody, I do not think that the staff could realistically have foreseen the actions the man would take.

50. PSO 2700 (Suicide prevention and self-harm management) says:

> "There is increased risk of suicide and self-harm among prisoners recalled from licences being served in the community. *All local prisons must put in place a strategy to respond to the needs of this group of prisoners."*

51. My investigator spoke to Holme House and asked for a copy of their strategy. He was told that it was included within their wider suicide and self-harm strategy. The relevant section is:

> "10.5 **Prisoners with a Change of Status**
>
> Reception and Induction staff must ensure they talk with prisoners (and accurately record this) who have-
>
> - Had a change of status (i.e. a new conviction, a new or extended sentence, a placement on the 'E' List or a re-categorisation).
> - Had a court appeal rejected.
> - Had a change in immigration status.
> - Been recalled to prison.
>
> Staff should also be aware of the potential for increased risk of suicide or self-harm among such prisoners and ensure the prisoner has undergone a healthcare screening. Reception staff must also make an entry in the prisoner's history sheet and inform the relevant wing/healthcare staff of the prisoner's change of status before location to healthcare/normal residential accommodation."

52. Reception and induction staff must speak to all new prisoners anyway and all prisoners must receive a reception healthscreen. So there are no additional mandatory actions for these prisoners, other than requesting wing and healthcare staff be told of the prisoner's change of status. With regard to that requirement, I am told that this consists of updating the electronic system with a note such as "licence recall from an IPP sentence."

53. The Governor and the safer custody team should consider further whether prisoners with a change of status require specific measures to safeguard them. The Holme House suicide and self-harm strategy correctly identifies as suffering from a "potential for increased risk of suicide or self-harm". There are plenty of options available to the prison, and I have seen varying ones in use at different prisons such as ensuring prisoners share a cell with a listener on their first night or ensuring that staff from the safer custody team visit them in their first few days back in prison. (Listeners are trained to support prisoners who may be at risk of suicide and/or self-harm.) However, I leave the specifics of any protocol up to Holme House. I am surprised that the required protocol for licence recall prisoners amounts to only one paragraph in the local suicide and self-harm strategy and there are no additional safeguards. I therefore make the following recommendation:

**The Governor should ensure that the risks presented by prisoners subject to licence recall are appropriately managed in accordance with the requirements of PSO 2700.**

## CONCLUSION

54. Staff have a responsibility to note and act upon prisoner behaviour that indicates they are at risk of harming themselves. The prison has a responsibility to support those prisoners who they judge to be at risk of harming themselves. They did not identify the man as at risk of harming himself and therefore did not take any action. When there are no apparent warning signs, it is very hard for staff to put in place strategies to safeguard prisoners.

55. As a licence recall prisoner, the man was in a higher risk category than most prisoners but he did not present any concerning behaviour. During his reception interviews he did not raise any concerns, and this behaviour continued on the induction unit. His cellmate was aware that he was subdued but did not suspect that he would harm himself. His cellmate was not sufficiently worried to raise any concerns with members of staff. I do not find that the prison missed any indication that he would take his life. However, I trust the Governor will consider measures to support prisoners following licence recall.

## RECOMMENDATIONS

1. The Head of Healthcare should remind staff that when a prisoner discloses previous mental health problems during the reception process, this should be followed up with a referral to the mental health services, in line with the prison's operation policy guidelines.

   **The National Offender Management Service accepted this recommendation and responded:**

   "All prisoners are currently referred with set criteria, however this will be extended to any prisoner who has a history of mental health issues even if not recent or under mental health services."

2. The Governor should ensure that the risks presented by prisoners subject to licence recall are appropriately managed in accordance with the requirements of PSO 2700.

   **The National Offender Management Service accepted this recommendation and provided a list of activities they are undertaking to manage the risks presented by prisoners subject to licence recall.**