PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of man at HMP Durham in March 2013

Our Vision

‘*To be a leading, independent investigatory body,*
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision’

This is the investigation report into the death of a man who died at HMP Durham in March 2013 after being found hanging in his cell. The man was 38 years old. I offer my condolences to the man's family and friends.

The investigation was carried out by an investigator. A clinical reviewer carried out a review of the clinical care the man received at Durham. The prison cooperated fully with the investigation.

The man, who was a student from Nigeria, was remanded into custody in September 2012 charged with sexual offences. This was his first time in prison. When he arrived, he said he had no thoughts of self-harm or suicide and he was not assessed as a risk of suicide or self-harm. Later, in October, he was offered mental health support after disclosing that he was feeling low and hopeless. He was prescribed anti-depressant medication but never received it.

In December 2012, a prison chaplain saw the man with a noose around his neck in his cell, but the response to this incident was confused and inadequate. As a result, he was not monitored under suicide and self-harm prevention procedures as he should have been. He was later discharged from the care of the mental health team, although he remained very pre-occupied about his forthcoming trial. He raised no concerns with healthcare staff who saw him in reception when he returned from court each day during his trial, but two days before his death he wrote to his solicitors and a friend indicating an intention to take his life. The letters were received after his death so neither were reported to the prison. Some prisoners said that the man had been subject to threats from other prisoners but we have been unable to find evidence to substantiate this.

I am concerned that, although diagnosed with depression, the man was not appropriately reviewed and did not receive the medication he was prescribed. Nor, at various times, was his risk of suicide fully considered. While assessing the risk a prisoner poses to himself is not an exact science, it should involve balancing the prisoner's demeanour and behaviour against known risk factors. Staff seem to have relied too much on the man's assertions that he did not intend to kill himself rather than balancing this against all his risk factors including his diagnosis of depression, the grave charges he was facing and the fact that he was in prison for the first time with little evident external support. However, it is not possible to know whether more effective assessment could have prevented the man's death.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **February 2014**

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SUMMARY

1. The man was remanded into custody in September 2012, charged with sexual offences. He was a student from Nigeria and had been living in the United Kingdom for five years. It was his first time in prison. At an initial health check, he said he had not had any previous mental health issues and had no thoughts of suicide and self-harm.

2. On 2 October, the man collapsed on the floor of his cell. He was conscious but did not respond to questions. His cell mate raised the alarm and officers asked for a nurse to attend as an emergency. Two prisoners later alleged that the officers treated the man roughly when taking him downstairs to the healthcare centre. It has not been possible to find any evidence to substantiate this account.

3. Paramedics were called and administered glucose intravenously before taking the man to hospital where he spent seven days under observation. He was diagnosed as having profound hypoglycaemia (low blood glucose). He had a number of tests on the function of his pancreas and an ultrasound scan, but the episode did not recur.

4. On 12 October, the mental health team assessed the man who disclosed that he was feeling low and helpless because of his imprisonment. He felt isolated as he had little external support and no one visited him in prison. The mental health team offered support and, on 18 October, a doctor prescribed an anti-depressant. The man never received the anti-depressant medication and the doctor did not check this or arrange a follow up appointment to review his progress.

5. On 4 December, a prison chaplain looked through the observation hatch in the man's cell door and saw him standing on a chair with a noose around his neck. The chaplain raised the alarm but when officers opened his cell, the man denied that he had been doing anything. Despite this concern, the chaplain did not open an ACCT document and the officers said that they were unaware of what the chaplain had seen.

6. The man's mental health support worker had an appointment with him on 12 December. The mental health support worker had heard that the man had been found with a noose but he did not question him about this and the man did not mention it.

7. On 21 January 2013, the mental health team discharged the man from their care, with the understanding that he could refer himself again if he needed to. He said that he was worried and preoccupied with thoughts about his forthcoming court case and was advised to engage in activities to help take his mind of it. He asked the pharmacy technician for the anti-depressant medication the doctor had prescribed. The doctor asked the technician to advise the man to make another appointment to see him as the gap between the original prescription and the request was too long. The man did not see the doctor again.

8. The man's trial began at the end of February. He went to court most days but, on 19 March, was not required. Another prisoner told us that, while the man was waiting on F wing to go to an education class, several prisoners threatened him and called him a rapist. The incident was not captured on CCTV and officers said that they had not seen it.

9. At about 5.10am on 24 March, the man's cell mate was woken by the night officer conducting a check who could not see the man. His cell mate saw that the man appeared to be hanging by a bed sheet on the other side of the cell toilet door. The night officer raised the alarm and he and other staff cut the man down. An ambulance was called. Prison nurses, joined by paramedics when they arrived, attempted cardiopulmonary resuscitation but the man could not be revived. He was pronounced dead by paramedics.

10. On 27 March, the man's solicitor contacted the Coroner to say he had received a letter from the man, delivered after his death, indicating that he intended to take his life. A former cell mate received a similar letter.

11. The investigation found that insufficient attention was given to the man's risk factors when assessing his risk of suicide and self- harm. It is also a concern that although diagnosed with depression the man was never reviewed by a GP and no one identified that he did not receive his medication. We have not found evidence that he was subject to threats from other prisoners, although the possibility cannot be discounted. As we have found in previous investigations at Durham, emergency procedures need improvement. We make four recommendations.

THE INVESTIGATION PROCESS

12. The investigator issued notices at HMP Durham informing staff and prisoners of the investigation and asking anyone who had relevant information to contact her. Two prisoners wrote expressing concern about the conduct of some prison officers on F wing, where the man had lived. One of them described an incident a few days before the man's death when the man had been threatened and intimidated by some other prisoners.

13. The investigator obtained copies of the man's prison and medical records and other relevant documents. She also viewed closed circuit television (CCTV) footage from 19 March 2013.

14. NHS England, commissioned Spectrum CIC to undertake a review of the clinical care the man received at Durham, which was carried out by a clinical reviewer.

15. The investigator interviewed staff and prisoners at Durham in May, June and August 2013. Two staff were interviewed by telephone and one former prisoner was contacted by letter and telephone but did not respond. The clinical reviewer interviewed a clinician by telephone as well as conducting three joint interviews with the investigator. After the interviews, she informed the Governor of the preliminary findings of the investigation.

16. HM Coroner for County Durham was informed of the investigation and provided a copy of the post-mortem report. The Coroner has been sent this investigation report.

17. The man's prison records did not contain a nominated next of kin but the Coroner's office had details of a family friend in the United Kingdom. One of the Ombudsman's family liaison officers, contacted his friend to explain the purpose of the investigation and invite him to raise any matters which he and the man's family wished the investigation to consider. The man's family received a copy of the draft report. His family asked:

    - What was the man's cause of death?
    - Were the prison negligent in their care of the man?
    - Was the man ever attacked while in prison?
    - Was he on remand or convicted?
    - Who was listed as his next of kin?
    - Was he ever in solitary confinement?
    - What medical treatment did the man receive?

HMP DURHAM

18. HMP Durham is a local prison that serves the courts of Durham, Tyneside and Cumbria. It can hold approximately 1,000 men. Primary healthcare is provided by Care UK and mental health services by Tees, Esk and Wear Valley NHS Trust.

19. At the time of the man's death Durham did not have a vulnerable prisoners' unit (VPU) for prisoners who might be at risk from others because of the nature of their offences or for other reasons. In April 2013, one was re-established after indicators that some prisoners did not feel safe dispersed amongst the general population.

Her Majesty's Inspectorate of Prisons

20. 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 identified a need for improvements in suicide and self-harm prevention procedures.

21. Many prisoners reported feeling unsafe and there was a significant number of assaults. Although inspectors found a good strategic approach to violence reduction, the low number of interventions for the number of violent incidents reported suggested a lack of staff awareness and use of the procedures.

Independent Monitoring Board

22. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who monitor all aspects of prison life to help ensure that proper standards of care and decency are maintained. In its most recent published annual report, the IMB noted that documentation to support suicide prevention and self-harm reduction continued to improve and that all instances of violence were captured by CCTV on the wings and investigated by the safer custody team.

Assessment, Care in Custody and Teamwork

23. Assessment, Care in Custody and Teamwork (ACCT), is the Prison Service process for supporting and monitoring prisoners at risk of harming themselves. An ACCT plan can be opened by anyone working in the prison. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of observations and interactions are set according to the perceived risk of harm. Part of the ACCT process involves drawing up a caremap to identify the prisoner's most urgent and pressing issues, set goals to help resolve the issues and identify who is responsible. The ACCT plan should not be closed until all of the actions on the caremap have been completed.

Previous deaths at Durham

24. Since 2010, there have been six apparently self-inflicted deaths at Durham including the man's. Three of those who died were unconvicted, in custody for the first time and hanged themselves from the cell toilet doors. In our investigation into a death by hanging at the prison the month before the man's death, we also drew attention to the need to consider all risk factors when assessing the risk of suicide and self-harm and the need for ambulances to be called immediately in an emergency, a matter we had also raised in other investigations at the prison.

KEY EVENTS

25. The man was a Nigerian student studying for a postgraduate degree at a local university. He had been in the United Kingdom for five years. The man was remanded into custody on 17 September 2012, charged with rape and sexual assault and taken to HMP Durham. It was the first time he had been in prison.

26. A staff nurse saw the man as part of the routine reception procedure for new prisoners. He answered questions about his health, including his mental health, and said he had not tried to harm himself before and did not have any mental health issues. He said he had no current feelings of suicide or self-harm.

27. An officer took the man to the First Night Centre, for newly arrived prisoners and interviewed him to ascertain his immediate needs. The man said that his family knew he was in custody. The role of Listeners, prisoners who are trained by the Samaritans to offer support to other prisoners, was explained and he was introduced to them. The system for making telephone calls using a personal identification number (PIN) was explained. Each prisoner has their own designated PIN which allows them to telephone authorised telephone numbers. He was given a PIN to make a telephone call that evening in case he wanted to let a family member or friend know where he was, but he did not use the telephone.

28. As with all newly arrived prisoners, a senior officer and nurse assessed the risk of him sharing a cell and found no reason to suggest he was likely to be violent towards another prisoner. They noted that it was his first time in custody. The nurse completed the healthcare section of the man's first night, induction and initial assessment and indicated that there were no self-harm issues, no ACCT had been opened and there were no other healthcare issues such as mental health problems or disability,

29. On 21 September, the man moved to F wing where he shared a cell with another prisoner. At the time, F wing was mainly for prisoners who were in employment or education and who were on the enhanced (highest) level of the incentives and earned privileges scheme which is designed to encourage compliance by rewarding positive behaviour with extra privileges. As a new prisoner, the man would not have had time to achieve enhanced status, but first night centre staff were able to select prisoners for F wing who were thought likely to fit in with the positive F wing ethos.

30. At about 5.00pm on 2 October, the man collapsed in his cell and his cellmate called for help by ringing the cell bell. Two officers responded and found the man lying on the floor of the cell conscious but unresponsive. An officer radioed for healthcare assistance. The nurse responded. She told the investigator that when she arrived she found the man's behaviour bizarre but could not find any apparent cause. She said that he was not talking coherently and his cell mate commented that he had been behaving strangely since the previous week when he had expected to be released at court but had not been. She took the man's blood pressure which was 161/94, which

was high and his pulse which was 81 bpm (within normal limits). She did not test his blood sugar level. She decided that the man needed to go to B wing (where the healthcare centre was temporarily based at the time) for observation and to see a GP.

31. Four officers carried the man downstairs to B wing each holding a limb, as the man was unable to stand up. A custodial manager, the most senior uniformed officer on duty who was present when the man was being moved, told the investigator that as a senior lead for advanced control and restraint techniques. He was very much aware of the importance of keeping a prisoner's head protected but could not recall a member of staff supporting the man's head. The custodial manager did not know whether the man's head had been banged on the stairs while he was being moved as the prisoner who had written to the investigator alleged but remembered the incident as the man had been screaming.

32. A prison GP, saw the man at about 6.00pm. The GP noted that the man had been incontinent of urine and was moaning and screaming bizarrely. The GP asked him whether he had taken any drugs or medication and he shook his head. The GP decided that the man needed an urgent hospital assessment and called an ambulance. Paramedics arrived and gave him hypostop (a concentrated glucose gel) and glucose intravenously which appeared to stabilise him. He would not say if he had taken any medication and was taken to the Emergency Department of the University Hospital of North Durham. As he was being discharged from the hospital at 1.12am on 3 October, the man collapsed again and was re-admitted for further tests and observation.

33. On 6 October, the man had an ultrasound scan of his pancreas for a suspected tumour. This showed a lesion on his abdominal wall, but a tumour was discounted. The significant hypoglycaemia was unexplained. On 9 October, he was discharged back to the prison and returned to F wing. He was prescribed Movicol sachets for constipation and paracetamol to take if necessary. He attended the hospital on 5 December for an abdominal ultrasound scan. The ultrasound appeared normal and there was no evidence of a cyst.

34. On 12 October, a community psychiatric nurse saw the man for a delayed assessment as he had been in hospital. The psychiatric nurse's role was to assess newly arrived prisoners and decide whether they needed support and at what level. The man told him he felt low because he was in prison and felt hopeless about his future. He said he did not feel suicidal but was struggling to understand his situation. The psychiatric nurse wrote in his clinical notes that the man looked well, had good eye contact and was articulate, if a little low. There was no evidence of anxiety or psychotic symptoms. His plan was to offer short-term, low-level mental health in-reach team support.

35. The man had an appointment with another prison GP on 18 October. He told the doctor that his sleep was poor, he was low in mood and that he had thoughts that he did not want to go on living although he did not have active thoughts about suicide. The doctor noted that the man's eye contact was

poor and his mood low and prescribed an anti-depressant, sertraline. There is no record that the man ever received this medication or that any follow-up appointment was made to review his progress.

36. The man's allocated caseworker in the mental health team saw the man on 23 October, when they discussed the events that had led to the man being remanded in custody and how being in prison was affecting his mood. The man said his sleep and eating patterns were erratic. He said he had distracting thoughts, sometimes about self-harming but said he had no plans to act on them. The mental health support worker suggested that the man find some employment in the prison to keep him occupied and that he would arrange to see him in three weeks time.

37. The caseworker next saw the man on 13 November. The man said that nothing had changed since their previous meeting and he was feeling the same. The mental health support worker asked whether he had felt any benefit from his medication. The man told him that he was not receiving any medication but the mental health support worker did not follow this up.

38. From 26 November, the man shared cell F4-27 with another prisoner until he was released on 8 January. In a telephone call, the prisoner told the investigator that they had a close relationship like brothers.

39. On 4 December, the prison's Roman Catholic Chaplain visited F wing as part of his pastoral duties. He intended to visit the man who regularly attended church services, a prayer group and bible study. The chaplain told the investigator that he opened the flap covering the observation panel of the man's cell door and saw him standing on a chair with a noose around his neck. He pressed the general alarm bell and shouted for help. Staff responded immediately and the acting senior officer opened the man's cell. The man walked out calmly as if nothing had happened. Officers searched his cell but found nothing. The man apologised to the chaplain and said that nothing had happened. They did not discuss the matter again.

40. The chaplain said that he had been very shaken by what he had seen. He went to speak to the coordinating chaplain who made an entry in the Chaplain's log of what had taken place. The chaplain told the investigator that he did not consider opening an ACCT plan because afterwards the man had seemed in very good spirits and had attended services at the Chapel as usual. He said he had later thought of opening an ACCT at the beginning of the man's trial but thought everything was going well. He did not record the noose incident in the wing observation book or on P-NOMIS (the computerised prison record system) as he thought the officers would do so.

41. The officer told the investigator that he had been temporarily promoted to senior officer at that time. He remembered the chaplain shouting for him. The officer said he got to the man's cell within seconds and shouted for other staff to assist. Someone had also pressed an emergency bell. He asked the chaplain what he had seen. He said that the chaplain just said that he had seen "something" but did not say exactly what. The officer opened the cell

door but the man said he had not been doing anything. He and another member of staff (it is not known who) had a quick look around the cell but did not know what he was looking for. He said the chaplain looked as if he had had a fright but did not say specifically what he had seen. The officer spoke to the chaplain in the wing office and he still just said that he had seen "something". The officer told the investigator that he had not questioned the chaplain further about what exactly he had seen. The officer said he had been unaware, until questioned by the investigator, that the chaplain had seen the man with a noose. He said that at the time he was bewildered about what had taken place and considered it a misunderstanding. He said that, had he realised the chaplain had seen the man with a noose, he would have opened an ACCT document and made sure that the incident was documented.

42. The man's cellmate, told the investigator that he had asked the man if it was true that the chaplain had seen him with a rope around his neck (It is not clear how the man's cellmate learnt about the incident). He said that the man did not deny it and had talked about taking his life. The cellmate said that he had tried to encourage the man to pray and study his bible more and reminded him that prison was not forever. The cellmate said he had seen the man with the rope in his cell although the man had tried to hide it. The cellmate said that one day he searched for and found a plaited rope, which he threw away. He did not report this to anyone.

43. On 12 December, the mental health support worker saw the man and noted that he seemed more relaxed than at previous meetings. The man told him that his court case had been adjourned until after the New Year. He said he was keeping occupied by attending education classes. The mental health support worker suggested that he should attend other activities such as remedial gym which the man said he would look into. The mental health support worker did not discuss the incident of the man apparently being seen with a noose. He told the investigator that, although he had heard it mentioned in the staff office, he did not raise it with the man and the man never brought it up.

44. The man's personal officer (An officer who is allocated a number of prisoners to get to know and support them and act as their first point of call for advice and complaints) wrote in the man's record on 13 December that he was a quiet person who tended to keep himself to himself.

45. The mental health support worker discussed the man's case with the psychiatric nurse on 17 December but did not mention the rumour about the man being seen with a noose. They decided that he would be offered one more appointment with a view to discharge.

46. The man's cellmate was released on 8 January 2013 and the man moved to cell F2-17 which he shared with another prisoner. The prisoner told the investigator that he got on very well with the man and found him a considerate person as the man allowed him to have the bottom bunk bed because he had

a heart condition. They enjoyed watching football on television and chatting. He said that the man was very religious and used to pray several times a day.

47. On 21 January, the mental health support worker had his last session with the man. They talked about the benefits of keeping occupied, especially as the man said he was constantly thinking about his trial and it was affecting his sleep. The mental health support worker reminded him that using the gym would be beneficial. The man said he did not have any plans to harm himself or take his life. After discussing the session with the psychiatric nurse, the mental health support worker decided to discharge the man from the mental health team's care on the understanding that he could refer himself again if he felt he needed support.

48. The man saw a nurse on 22 January and asked for some cream as his skin was dry. She examined his arms and legs and agreed to give him some aqueous cream. He told her he was depressed and under the care of the mental health team. He also complained of toothache and asked to see the dentist. (He was given an appointment for 13 February but did not attend.)

49. On 24 January, the man went to the treatments room and asked for his anti-depressant medication. A pharmacy technician, explained that, because the medication had never been issued since the initial GP prescription in October 2012, she would need to speak to the original prescriber. The doctor said that the man would need to make a new appointment as a three month gap was too long to issue medication without seeing the patient. The pharmacy technician wrote in the clinical record that she would explain this to the man the next day when she issued him with the aqueous cream. There is no record that this was done and the man did not make any further appointment to see the doctor or any other doctor.

50. The man's trial began on 28 February. He attended court 11 times between then and 22 March and a nurse or healthcare support worker saw him in reception each time he returned. There is no evidence that he raised any worries and they did not record any concerns.

51. A prisoner on F wing wrote to the investigator and said that a few days before the man's death, another prisoner had said he had been in the wing office when an officer pointed to the computer screen which was showing the man's photograph and the details of his alleged offence. He said that two days before the man's death, he witnessed a hostile situation on F wing where a number of prisoners surrounded the man and verbally abused him and threatened to attack him. He alleged that officers saw what was happening but none of them showed any concern. He added that the man was the only black prisoner on F wing and racial abuse was a common occurrence in Durham although, as a person of mixed heritage, he had not experienced it personally.

52. A prisoner said he was chatting with a friend while waiting to leave the wing with other prisoners who were going to activities between 8.00 and 8.30am. He said he saw a few prisoners surround the man who was standing on the

left of the wing near the telephones. He said the prisoners were making comments to the man such as “you rapist”, “you wrong one”, “you fucked it”. The prisoner said he saw a couple of officers look over but they did not attempt to diffuse the situation. The prisoner said the man looked very confused and very scared but as the situation looked hostile The prisoner did not want to get involved.

53. The investigator checked the man’s movements in the days leading up to his death. He attended court every day that week except for 19 March, when he went to education. She asked the prison to provide CCTV footage covering F wing at that time. The coverage was restricted as it was from fixed cameras which have blind spots on the wing. A large group of prisoners can be seen waiting on the ground floor but the camera faces away from the left hand area around the telephone so it is not possible to see anything happening there. The footage shows two officers on the ground floor, waiting for movements to begin. An officer was at a table preparing to check the names of prisoners leaving the wing against his list. Another officer controlled the flow of prisoners passing another officer letting only a few at a time through. Behind an officer there was a large group of prisoners milling around but one can only clearly see those in the corridor entrance. The cameras do not pick up any other staff on the wing. The man gave his name to the officer at 8.29am and left the wing. The officer told the investigator that the area was out of the sight and hearing of staff and it was possible that verbal abuse had taken place without being noticed.

54. The man last attended court on Friday 22 March. As on previous occasions, a member of healthcare staff saw him when he returned to the prison as part of the reception routines. It was noted that he did not raise any concerns. According to his records, he was due to return on Monday 25 March for the jury’s verdict. On Saturday 23 March, the man put his name on the list to attend the Roman Catholic service the next day as usual. He collected his evening meal at 5.00pm as did his new cell mate. They did not converse while the cellmate watched television, the man prayed in the separate cell toilet and wash room as he often did. Originally the cellmate told the police that the man put two envelopes next to the kettle on the table that night, one addressed to someone in Newcastle and the other to his solicitor. Later, the man’s cellmate told our investigator that this could have been a day or two before. The man’s cellmate said he fell asleep with the television on at about 11.30pm and slept until a member of staff knocked on the cell door and asked about the man.

55. An operational support grade (OSG) was on duty on the night of 23 March. He took over duty on F and I wings at about 7.30pm and counted all the prisoners and checked that their cell doors were secure. He patrolled the wings during the night. At about 4.45am on 24 March, the OSG began to check that all prisoners were present. When he reached the man’s cell at about 5.10am and looked through the observation panel, he saw that the bed sheets of the lower bunk had been rolled back but there was no occupant. He looked through the toilet observation panel but the light was off and no one appeared to be using it. He knocked on the observation panel until the man’s

cell mate woke and he asked him where the man was. When the man's cell mate looked across to the toilet door, he saw a sheet over the top and the man's feet dangling at the bottom and told the OSG what he could see.

56. At 5.15am, the OSG radioed requesting assistance and said he had found a 'ligature.' A custodial manager was the night orderly officer (the most senior member of staff on duty) and asked for more details. The OSG confirmed that he had found a prisoner with a ligature around his neck. The custodial manager instructed him to enter the cell if it was safe to do so by breaking the seal on his night pouch and using the cell key inside carried for use in an emergency. The custodial manager and other colleagues, including nurses, arrived at F wing within a minute. The custodial manager asked the man's cell mate, who was still sitting on the top bunk, to leave the cell and using his ligature-cutting knife, a small bladed tool that prison officers carry, he cut the sheet from the man's neck. The man was not breathing and two nurses began cardiopulmonary resuscitation (CPR – a mixture of rescue breaths and chest compressions to keep blood and oxygen circulating around the body). The custodial manager requested an emergency ambulance at 5.20am, which arrived at Durham at 5.27am. Paramedics assisted with CPR but their monitoring equipment showed that there was no electrical activity in the man's heart. They pronounced him dead at 5.50am on 24 March.

57. On 27 March, the man's solicitor contacted the coroner to say that he had received an undated letter from his client on 26 March (two days after his death) indicating that could not bear to be in prison for an offence he said he had not committed. The man wrote that he would "rather sleep in death" than serve a sentence for "false crimes".

58. The investigator contacted the man's previous cell mate who had shared a cell with the man until January 2013, as the man had written to him two days before his death. The former prisoner said that the man wrote in the letter that he was going to take his life and gave him instructions on who he should send his money to. [The man had sent his debit card to the former prisoner in January so that he could send money to his family in Nigeria on his behalf.] The former prisoner said that because of the man's strong Christian belief, he had not believed that the man would kill himself. He was unable to find the letter but recalled that the man had been angry about how his court case was progressing and referred to himself as being "no more".

59. According to his prison records the man did not receive any social visits from family or friends during his time at Durham. The only numbers he asked to be added to his telephone account were those of the Nigerian High Commission, the man's previous cell mate and someone who he described as a friend in Nigeria. The man's previous cell mate told the investigator that he had tried to book a visit to see the man as he had bought him some new clothes for his court appearance but he was unable to get through to the telephone booking line to arrange a visit. The man's telephone call record for March 2013 shows two telephone numbers in Nigeria that he was allowed to call but the records do not indicate who the recipients were. The last telephone call he made was

on 20 March to a number in Nigeria. The call lasted 42 seconds. The prison did not have a recording of this call.

Contact with the man's family

60. A Supervising Officer (SO) was appointed as the prison's family liaison officer on 24 March. There was no nominated next of kin recorded on the man's prison records. On 25 March, the family liaison officer asked the prison's police liaison officer to check police records for any family contact details but none could be found. She asked the immigration authorities and the Nigerian High Commission if they could assist. On 26 March, immigration officials provided some information and the next day the Nigerian High Commission gave the prison the family contact details the man had provided as part of his visa application. With the help of the Coroner's office, a family friend resident in the United Kingdom arranged for the man's body to be repatriated to Nigeria. In line with national guidance, the prison offered to cover the cost of repatriation. Contact with his family in Nigeria was conducted through the family friend.

Support for prisoners and staff

61. A notice posted in the prison informed prisoners of the man's death. None of the F wing prisoners the investigator spoke to said they had been told in person. The man's cell mate said he had had to ask what had happened to the man before he was told. He said he had asked to speak to someone from the mental health team but it was 2 April before he did, although a chaplain came to see him and then a Listener. He did not consider he had received sufficient support. He said he was given a succession of different cell mates afterwards despite telling staff that he wanted to be left alone because "once you find somebody hanging there, you don't want to be put in that situation again. You don't want to share a cell with somebody where it can happen again."

62. Two other prisoners said they had learnt of the man's death when they heard other prisoners talking about it. One prisoner said he had heard a rumour at lunchtime that someone had committed suicide and later found out it was the man who had died.

63. The staff we interviewed who were directly involved said that they had been well supported by the prison after the man's death. Those directly involved with the emergency response attended a meeting that day, chaired by an operational manager, during which they were offered further support and given an opportunity to talk about the incident. At the meeting, the OSG said that he had not received any training on what to do if he found a prisoner hanging.

Post-mortem report

64. The post-mortem report indicated that the man died as a result of hanging.

ISSUES

Clinical care

65. On 2 October 2012, the man was assessed by healthcare staff in his cell as he was behaving strangely. We have found no clear evidence to support the allegations of prisoners that he was roughly handled and hit his head when officers took him the healthcare centre and there were no direct prisoner witnesses to interview. The man was examined by healthcare staff at the prison and appropriately referred to the local hospital as an emergency who reported no injury to his head. He remained in hospital until 11 October. He was found to have hypoglycaemia with no obvious cause, and there was no reoccurrence of this condition. The clinical reviewer is satisfied that this hypoglycaemic incident was appropriately managed by prison healthcare staff.

Mental healthcare

66. On 17 September 2012, the man had a health screen assessment when he arrived at HMP Durham as part of the reception process. He said he did not have any thoughts of suicide or self-harm. On 12 October, the nurse, a member of the mental health in-reach team saw the man as part of a routine assessment for newly arrived prisoners which had been delayed because of his admission to hospital. The man said that he felt low and felt hopeless about his future, but said that he did not intend to take his life. The nurse decided there was no evidence of anxiety or psychotic symptoms and offered short term, low level support.

67. On 18 October, a prison GP, prescribed an anti-depressant for the man but it does not appear that he ever received this. The GP did not arrange a follow-up appointment to check how the man was progressing with the medication.

68. When the mental health support worker saw the man on 23 October, the man said he was in low mood and having thoughts about self-harm, but he did not intend to carry them out. The mental health support worker made no reference to his medication. The mental health support worker saw the man again on 13 November and, at that appointment, asked him whether the anti-depressant medication had been beneficial. Although the man told him that he had not received the medication this was not followed up. The mental health support worker considered it possible that the man had decided not to take the medication but he did not check this with him at this or subsequent appointments. The mental health support worker saw the man again on 12 December and 21 January 2013 when he noted that the man still suffered from insomnia because he was worried about his court hearing, but did not express any thoughts of suicide or self-harm. The man was then discharged from the care of the mental health team.

69. The clinical reviewer notes that a follow-up appointment, after the man was prescribed anti-depressants, should have been made in accordance with the

National Institute for Clinical Excellence (NICE) guidelines for the treatment and management of depression. These state:

a. "for people started on anti-depressants who are not considered to be at increased risk of suicide, normally see them after 2 weeks. See them regularly thereafter, for examples at intervals of 2 to 4 weeks in the first 3 months, and then at longer intervals if the response is good".

70. It is surprising that the man was discharged from the mental health team approximately five weeks before his court hearing began when the man had repeatedly identified his pending trial as the trigger for his low mood, but the clinical reviewer notes that there was a "safety net" decision that the man could be re-referred to the team at any point, which he considered reasonable. A member of healthcare staff saw the man each day he returned from court (a total of 10 separate occasions) but no concerns were identified.

71. We are concerned that the doctor did not review the man after prescribing anti-depressant medication. It is also a concern that the fact that his medication had not been issued to him was not identified or followed up, even after he told the mental health worker, on 13 November, that he had not received it. We make the following recommendations:

The Head of Healthcare should ensure, in line with NICE guidelines, that follow-up appointments are made to review the progress of prisoners prescribed anti-depressants.

The Head of Healthcare should ensure that when prescribed medication has not been received by the patient, this is identified and followed up with the pharmacy or prescriber.

Assessing risk of suicide and self-harm

72. The man was a foreign national prisoner remanded to HMP Durham charged with serious sex offences. This was his first time in prison and he consistently denied his offences. He told healthcare staff, including members of the mental healthcare team that he was low in mood and was not sleeping. He was diagnosed with depression. The man repeatedly said that he was worried about his court case. On at least two occasions he said he did not want to go on living or said he had suicidal thoughts, although it was noted that he said he had no plans to carry this out. He was isolated and received no visits in prison, apart from his solicitor. The man was found hanging the day before he was due to hear the verdict in his trial.

73. Prison Service Instruction (PSI) 64/2011 covering safer custody, sets out a number of risks and triggers for both self-harm and suicide. These include a lack of social support, early days in custody, being single, a diagnosis of mental illness such as depression, hopelessness, suicidal ideation and offence – particularly those charged with violence against another person. Court appearances, especially the start of a trial and sentencing are noted as triggers which can increase the risk of suicide and self-harm. All of these

factors applied in the man's case but it is not apparent that they were taken into account in assessing his risk of suicide and self-harm or what weight was given to them if they were.

74. The clinical reviewer considers it is likely the man was intent on committing suicide and wished to hide this from professionals. However, we are not satisfied that the man's risk of suicide was fully considered and all his known risk factors taken into account. Too much reliance appears to have been placed on his statements that he did not intend to carry out his thoughts of suicide rather than assessing the full picture. Had this been done it is likely that an ACCT plan to support him would have been opened under Prison Service suicide prevention procedures. Sadly, it is not possible to know whether this would have prevented his death.

75. It is a particular concern that an ACCT was not opened on the occasion that one of the chaplains saw the man in his cell standing on a chair with a noose around his neck on 4 December 2012. There is considerable confusion about what happened that day. Although officers attended and checked the man's cell in response to the chaplain raising the alarm, they said they did not know what the concern had been and what they were looking for. This is hard to understand. There were no notes made in the wing records, although the coordinating chaplain made an entry in the chaplaincy log about what the chaplain had seen.

76. The chaplain told the investigator that he was sure that he had seen the man with a noose around his neck, but he was unable to explain why he had not made this clear to officers at the time. We find it surprising and inexplicable that the officers involved did not clarify the reason for the call for help. Some staff must have known that the man had been seen with a noose as the mental health support worker, the man's mental health worker, said that he had been aware of the incident. He said that he did not discuss it with the man as there was no concrete evidence. We consider that he should have done. It is also apparent that the man's cell mate heard about the incident as he later challenged the man about it.

77. Whatever the reasons for this confusion, suicide and self-harm prevention procedures should have begun. There can be few clearer signs that a prisoner is at risk of suicide than seeing him standing on a chair with a noose around his neck. The chaplain did not do open an ACCT plan, possibly because he was so shocked by the incident, but neither did the coordinating chaplain suggest it or open one himself when the chaplain told him what had happened. The officers involved said they were unaware of what had happened so neither did they.

78. While it is not possible to know whether supporting the man through ACCT procedures would have changed the outcome, it is a concern that there were a number of occasions at Durham when it does not appear his risk of suicide and self-harm was properly assessed. We make the following recommendation:

The Governor should ensure that all known risk factors are fully considered when determining a prisoner's risk of suicide and self-harm and that an ACCT is opened whenever there is an indication that the prisoner is at risk.

Alleged intimidation

79. It was alleged that not long before the man's death an officer indicated to a prisoner in the wing office details of the man's charges which were on the office computer. The prisoner who made the allegation said he later saw the man being verbally abused and threatened and officers did not intervene. Another prisoner told the investigator that he had seen the man being verbally abused by a group of prisoners because of the charges against him.

80. The investigator identified the day these allegations referred to and examined CCTV footage of the wing. Unfortunately there is a 'blind spot' exactly where the alleged abuse took place, although a large group of prisoners can be seen in the area. Two officers were on duty overseeing prisoners leaving the wing to go to activities. One of the officers told the investigator that he was aware that there was a blind spot on the wing, which was not covered by CCTV, and it was also difficult for officers to supervise this area during movements to activities when only two were on duty.

81. Because of the lack of available evidence we have not been able to substantiate any of these accounts, but it is a concern that the man might have been verbally abused and threatened which would have increased his feelings of despair. The account of what allegedly occurred in the wing office is troubling but again unsubstantiated.

82. We note that the last inspection of Durham carried out by HM Inspectorate of Prisons, indicated that many prisoners reported to inspectors feeling unsafe and the Inspectorate drew attention to the fact that there were a significant number of assaults yet few interventions by staff. Previously Durham did not have a vulnerable prisoners unit to hold separately prisoners at risk from others because of the nature of their offences – usually sexual. This was a laudable attempt not to collude with prisoners' 'hierarchy' of acceptable offences but did not always result in prisoners at risk of threat being protected. Since the inspection, and subsequent to the man's death, a vulnerable prisoners unit has been established at Durham to help prevent intimidation of prisoners because of the nature of their charges or offences. While the existence of a blind spot for CCTV on F wing indicates a need for better supervision when prisoners congregate there, we consider that the opening of a unit to protect vulnerable should help future such incidents directed at prisoners charged or convicted of sex offences.

Emergency response

83. When the OSG first identified at 5.15am that the man appeared to be hanging in his cell he radioed for assistance and reported that he "had found a ligature". The night orderly officer asked for more detail before he instructed

the OSG to enter the cell using the key carried for emergencies. Further help arrived, including nursing staff, within a minute. CPR was commenced immediately and an ambulance was called at 5.20am, paramedics arrived at 5.27am.

84. Although Durham had a protocol for an ambulance to be called automatically when an emergency code is called, as we have found in previous investigations at the prison, the protocol and expected emergency procedures were not followed. This is a continuing concern. The ambulance should have been called at least five minutes earlier if the OSG had used an appropriate emergency code. The night orderly officer should have called an ambulance immediately he became aware a prisoner was hanging. While there was no inordinate delay and there is no indication that this affected the outcome for the man, in an emergency every minute counts.

85. PSI 03/2013 Medical Emergency Response Codes which was introduced on 1 February and became mandatory on 28 February, just weeks before the man's death, requires all prisons to have an emergency code system for calling an emergency over the radio network, usually 'Code Red' (for blood loss/ burns/factures) and 'Code Blue' (for chest pain/, breathing difficulties/ unconsciousness). The advantage of a code system is that each code can alert staff to the specific type of emergency, enabling the appropriate equipment to be brought to the emergency. When an emergency code is called the control room should call an ambulance automatically. We make the following recommendation:

The Governor should ensure, in line with PSI 03/2013, that all staff fully understand and adhere to a protocol for the use of emergency codes and that an ambulance is called automatically in such circumstances.

Support for prisoners following the man's death

86. We consider that prisoners were appropriately informed and supported after the man's death. Although the man's cell mate said he did not feel well supported we have investigated and are satisfied that the prison appreciated that he had been through a traumatic experience and offered appropriate support for the man's cell mate who was himself vulnerable. On the day of the man's death, a Sunday, a prison chaplain and a Listener went to see him and a mental health appointment was arranged for the next week.

RECOMMENDATIONS

1. The Head of Healthcare should ensure, in line with NICE guidelines, that follow-up appointments are made to review the progress of prisoners prescribed anti-depressants.

2. The Head of Healthcare should ensure that when prescribed medication has not been received by the patient, this is identified and followed up with the pharmacy or prescriber.

3. The Governor should ensure that all known risk factors are fully considered when determining a prisoner's risk of suicide and self-harm and that an ACCT is opened whenever there is an indication that the prisoner is at risk.

4. The Governor should ensure, in line with PSI 03/2013, that all staff fully understand and adhere to a protocol for the use of emergency codes and that an ambulance is called automatically in such circumstances.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Head of Healthcare should ensure, in line with NICE guidelines, that follow-up appointments are made to review the progress of prisoners prescribed anti-depressants.	Accepted	NICE guidelines Depression primary care to be cascaded via The Gables to all prison GP's Quarterly audit of compliance to NICE guideline. Recommendation to be brought to the attention of other Head's of Healthcare NE prisons.	1st December 2013 1st December 2013	Completed
2	The Head of Healthcare should ensure that when prescribed medication has not been received by the patient, this is identified and followed up with the pharmacy or prescriber.	Accepted	All staff who administer medication to be reminded that they must ascertain why a *did not attend* (DNA) for medication has occurred and make a record of this upon the patient Kardex and/or check In possession medication prescriptions and medicines to ensure that patients have collected their prescribed medication. Recommendation to be brought to the attention of other Head's of Healthcare NE prisons & TEWV Patients who DNA for their medication must be brought to the attention of the prescribing professional, via System 1 to ensure that a traceable record can be evidenced. Quarterly audit of 25% live prescriptions to verify compliance with above	1st December 2013 1st December 2013 1st December 2013	

3	The Governor should ensure that all known risk factors are fully considered when determining a prisoner's risk of suicide and self-harm and that an ACCT is opened whenever there is an indication that the prisoner is at risk.	Accepted	Consideration will be given to opening an ACCT document after consultation with reception medical staff, ascertaining all known risk factors for any prisoner showing signs of distress, or indicating self harm intentions upon arrival at reception. All information will be completed on the concern and keep safe form. This information will be considered by first night centre band 4 managers when completing the immediate action plan. This is to ensure that the person in distress receives appropriate support and located accordingly. All obtained information which has been entered on the concern and keep safe form will be entered onto C-Nomis case notes by Induction Unit night staff. This will be monitored by the Safer Custody team during their weekly checks.	1st December 2013 1st December 2013 1st December 2013 1st December 2013	
4	The Governor should ensure, in line with PSI 03/2013, that all staff fully understand and adhere to a protocol for the use of emergency codes and that an ambulance is called automatically in such circumstances.	Accepted	To issue a global email to all staff reminding them of the emergency codes, protocol and procedures. To add to the agenda of the monthly staff meetings, to reiterate the correct procedures required in cases of emergency. All staff working within the ECR are now fully aware of the correct procedures following a Code Blue emergency and that an ambulance is called immediately.	1st December 2013 1st December 2013	Completed