

**Investigation into the circumstances surrounding the
death of a man
at HMP Durham in April 2012**

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

July 2013

This is the report of an investigation into the death of a man, a prisoner at HMP Durham, who was found hanging in his cell in April 2012. He was 29 years old. I offer my condolences to his family and friends.

County Durham Primary Care Trust appointed a clinical reviewer to conduct a review of the man's clinical care in custody. HMP Durham co-operated fully with the investigation.

The man was on remand, charged with two serious assaults, one against his girlfriend. It was not his first time in prison and he expected a long prison sentence if convicted. On arrival at Durham, he told staff that he had self-harmed many years before. The nurse and doctor who saw him had no concerns about his physical or mental health.

The investigator was told of rumours in the prison that a prisoner who had a grudge against the man was planning to arrange for another prisoner to harm him but we found no evidence that he was being intimidated or had been assaulted. Nor was there any indication that the man was aware of any threats against him.

The man was facing a number of difficult issues, but he gave no indication that he was seriously affected by them or that he was depressed. None of the prisoners or staff interviewed during the investigation saw anything that made them worry about him and they were shocked by his death. On the night he died, it was the first time, since arriving at Durham, that he had been alone in a cell overnight. I am satisfied that there was little the prison could have done to predict or prevent his death. While nothing could have been done to save the man, after his death, the Governor promptly rectified some omissions that the investigator had identified in the prison's emergency procedures, as a result no recommendations are made.

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.

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SUMMARY

1. The man was remanded into custody on 5 November 2011, and taken to HMP Durham. It was neither his first time in prison nor at Durham. He was charged with two counts of serious assault, one of which was against his girlfriend.
2. During his first reception health screen, the man told the nurse that he had previously attempted to harm himself many years before, but had never done so in prison. The nurse, who was a registered mental health nurse, and the doctor who saw him afterwards, had no concerns about the man's physical or mental health.
3. On 21 April, the man telephoned his father. He spoke about his court date at the end of the month and his defence. He was aware that, if convicted, he faced a long term of imprisonment. He did not mention any other issues. Two days later, the man's cellmate moved to another cell. That night was the first time since his arrival in Durham that he had been on his own in a cell overnight.
4. At around 5.00am the following morning, the night patrol officer on duty on B wing saw the man hanging by a bed sheet from the top bunk bed. He summoned assistance, although he did not use the required emergency code. He then returned to the office on the floor above to collect the cut-down tool he should have been carrying on his belt. He returned, then he and the other staff who had responded to his call opened the cell door and went in. They cut through the strip of bed sheet and lowered the man to the floor.
5. Two nurses examined the man and concluded that he had been dead for some time. They decided not to attempt to resuscitate him and the ambulance staff, when they arrived, agreed with the decision.
6. Family liaison officers had difficulty contacting the man's family but eventually met his mother in the afternoon and his father the following morning. They broke the news of his death and offered support.
7. Two weeks after the man's death, his girlfriend wrote to the Governor, alleging that two prisoners, whom she named, had bullied and "tormented" her boyfriend. The two men had been in Durham at the same as the man but there is no evidence of any contact between them in prison. Two prisoners told the investigator of rumours that the man was being bullied or threatened but neither had seen any sign of it. None of the officers or prisoners we spoke to had any knowledge of threats or bullying.
8. The investigation found that the man was managed appropriately at Durham and the Governor promptly rectified deficiencies in the emergency response guidance, identified during the investigation.

THE INVESTIGATION PROCESS

9. The Ombudsman's office was notified of the man's death on 24 April 2012. The investigator visited HMP Durham on 3 May, where she met the Deputy Governor and members of the Independent Monitoring Board (IMB) and the Prison Officers' Association. She visited the man's cell and collected relevant documents. She also interviewed the inmate who had been the man's cellmate until the day before his death.
10. Notices of the investigation were issued to staff and prisoners, inviting them to provide information about the man's death. No one came forward.
11. The investigator interviewed a number of staff and prisoners on 28 June and 6 July. She gave verbal feedback on the progress of the investigation to the Governor after the interviews were completed. County Durham Primary Care Trust commissioned a clinical reviewer to review the clinical care the man received at Durham.
12. During the investigation, the OSG who discovered the man was on sick leave as a result of the events of that morning. We therefore decided not to interview him. The information about his actions was obtained from his statement, written on the morning of the man's death, and from the accounts of other staff.
13. One of the Ombudsman's family liaison officers contacted the man's father and mother to explain the purpose of the investigation and invite them to identify any matters they wished the investigation to consider. His family did not raise any issues.
14. During the course of the investigation, the man's girlfriend wrote to the Governor of HMP Durham about her concerns that her boyfriend had been bullied. The Governor passed the letter to the investigator, who looked into this as part of the investigation.

HMP DURHAM

15. 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 Inspectorate of Prisons

16. The most recent inspection by HM Inspectorate of Prisons took place in October 2011. Inspectors found that there had been improvements since the previous inspection but there was still much to be done. Inspectors noted that, while there was a clear violence reduction policy, in practice the scheme was seldom used and the number of prisoners on formal anti-bullying measures was disproportionately low for the number of violent incidents.

Independent Monitoring Board (IMB)

17. 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 was positive about the violence reduction (VR) strategy and noted that violent incidents were captured by CCTV on all wings and investigated by the Safer Custody Team.

Previous Deaths at Durham

18. There were four deaths at HMP Durham in the year before the man's death. None of the circumstances were similar to those of this man's.

KEY EVENTS

19. The man appeared at Sunderland Magistrates' Court on 5 November 2011. He was charged with assaulting his girlfriend and a male friend during a fight the previous day. He was remanded into custody at Durham. It was not his first time in prison and, during a previous sentence, he had been in Durham.
20. A registered mental nurse (RMN) carried out a reception health screen. The man told the nurse that he had not used drugs in the previous month, had no outstanding hospital or GP appointments and was not taking any medication. He said that he had last seen a doctor a week earlier for treatment of a kidney infection.
21. The man said he had no thoughts of suicide or self-harm. He told the nurse that he had cut his wrists when he was 13 years old. It is also recorded that he had taken an overdose of tablets in 2001, but he had never tried to harm himself in prison. The nurse told the investigator that he had no concerns about the man's mental health to lead him to refer him for a mental health assessment.
22. Based on what the man told him, the nurse assessed his weekly alcohol consumption as just within the maximum recommended. He said that he had injured someone as a result of drinking, so the nurse referred him to the duty doctor to consider an alcohol detoxification programme. He saw a doctor who decided an alcohol detoxification was not necessary, but recorded that staff should monitor him for alcohol withdrawal or any sign of intoxication. Healthcare staff monitored him overnight and, the following morning, he declined to see anyone from the substance misuse team.
23. Healthcare staff received the man's medical records from his GP in the community on 9 October and the GP noted that he was not on any medication. The only other entry in the medical records before the man's death is a note that he refused the offer of a vaccination on 13 December.
24. From 5 to 8 November, the man went through the induction process on E wing, where he remained until 14 November when he moved to B wing. On 8 December, he moved to cell B1-16, which he shared with a fellow inmate. The two men got on well together. When the man was on B1 landing, it was restricted to prisoners on the enhanced level of the Incentives and Earned Privileges (IEP) scheme (a rewards and sanctions scheme to encourage good behaviour), wing cleaners and prisoners whom staff judged to be good workers. The landing is a small, sub-basement unit down a flight of steps from the ground floor level (B2 landing). At the top of the stairs there is an iron gate, and usually a member of staff stands there to stop unauthorised prisoners going down to B1. He was not originally an enhanced level prisoner but gained that status in January 2012.
25. At the beginning of January 2012, the police officer in charge of the case against the man contacted the prison. She said that the man's girlfriend, whom she described as a witness in the case, had told her that her boyfriend had

been making unwanted phone calls to her and her family. Security staff at the prison then blocked her telephone number on the man's telephone account, so he could not contact her. They also noted her address to prevent him sending letters to her.

26. The man's telephone records show that the last time he called his girlfriend's number was 28 December, when he spoke for ten minutes. After the man's death, letters were found in his cell from several family members and friends, including his girlfriend. The letters suggests that his girlfriend had different reasons for stopping contact with him which he was aware of. His cellmate told the investigator that the man had said that the prosecution did not want her to have contact with him and that he wrote to her through a mutual friend.
27. On 13 February, a newly arrived prisoner told an officer that before coming to prison the man had attacked him with a machete and he was in fear of his life. Staff noted on the computer system that the man and the newly arrived prisoner had to be kept separate from each other. The prisoner was accommodated on A wing. His brother arrived at Durham on 23 December 2011, but did not mention the man and so there was no "keep separate" entry for him. Prison staff did not know of his connection to the man until after his death, when his girlfriend wrote to the Governor alleging that the brothers had bullied and "tormented" her boyfriend.
28. The investigator examined records showing which wings the brothers were on and cross-referenced them with the man's cell on B1 landing. She also obtained their visits and healthcare appointments information and again compared the movements of the three men to see if they were ever in the same location. The records show that the men did not ever have a healthcare appointment at the same time, so they could not have met in the waiting room in the healthcare centre. The first brother to arrive at the prison did not have any visits at the same time as the man. On 19 February, his brother and the man had a visit at the same time but there is nothing in the documents seen by the investigator to indicate that there was any incident or even that the two men met or spoke.
29. The second brother's records show that he was on B wing at the same time as the man. However, his cell was on the third floor (B4 landing). As explained earlier in the report, prisoners on B2, B3 and B4 were not permitted to go down to B1 landing. So, although both the man and the second brother to arrive at the prison were on B wing at the same time, the physical layout would have kept them apart.
30. The man's cellmate told the investigator that he had heard that a prisoner, whom he refused to name, was going to persuade another prisoner to assault his cellmate. He did not know if the man was aware of this and did not discuss the matter with him.
31. On 21 April, the man telephoned his father. The investigator examined a transcript of the call. The man said that he had withdrawn his defence statement, in which he had described his actions during the incident that led to

the charges against him. He had not sought the advice of his lawyers before doing so but was due to have a legal visit later that week, in preparation for his next court appearance on 30 April. The rest of the conversation dealt with family matters. He did not say anything about his life in the prison and did not mention any problems.

32. Two days later, an officer introduced himself to the man and his cellmate as their new personal officer. The same day, the man's cellmate was made a wing cleaner, a job that usually means that the prisoner is given a single cell. He moved to a new cell in the afternoon leaving the man with the cell to himself until a new cellmate was allocated.
33. The man returned from work between 3.45 and 4.00pm. His personal officer allowed him to have a shower before he was locked up. As he went into his cell afterwards, his personal officer told him that his cellmate had moved out and that they would try and move someone else in the following day. The officer told the investigator that nothing the man said or did gave him any cause for concern. This was the first time since arriving at Durham that the man had been on his own in a cell overnight.

Morning of the man's death

34. At 9.00pm the prison went into night patrol state. Prisons operate at night with a reduced staff. A senior officer was the night orderly officer, the most senior officer on duty in the prison. He had an assistant night orderly officer. The wings were patrolled by officers and Operational Support Grade (OSG) staff. During the night only the night orderly officer carries a full set of keys to unlock all gates, doors and cells. The officers and OSGs are each issued with a cell key in a sealed pouch for use in emergencies. The staff instructions are that during the night state, a cell may only be unlocked by a single member of staff where there is, or appears to be, immediate danger to life.
35. An OSG began a morning count of prisoners on B wing at approximately 5.00am. When he looked through the observation panel of the man's cell, he saw him sitting almost on the floor with a noose around his neck attached to the side of the top bunk bed. The OSG called for the night orderly officer and his assistant as well as the emergency response nurse to assist him. Then he ran upstairs to collect the cut-down tool that he should have been carrying on his belt. He returned to the cell and was trying to use his emergency key to open the door when an officer and OSG arrived.
36. The night orderly officer was in an office at the gate of the prison when he heard the OSG's call for assistance. He asked what the emergency was and the OSG said that it was a hanging. The night orderly officer estimated that it took him about a minute to run to B1. The officer who was joint second to arrive on scene took the key from the OSG and opened the man's door. He also took the OSG's cut-down tool and entered the cell, followed by an OSG and the night orderly officer who asked the control room staff to call an ambulance. The officer asked the night orderly officer to support the man while he cut the strip of bed sheet by which he was hanging and they moved him to

the floor. They noticed that he was very cold and stiff and his body remained in a sitting position.

37. A nurse was on the second floor landing of E wing when she heard the OSG's call. Within seconds, she heard that it was a prisoner hanging so she called to a colleague to collect the emergency equipment. By the time she reached the ground floor, her colleague had collected the emergency bags and the two nurses ran to B1. When they went into the cell, the officer and the night orderly officer left.
38. The nurse who heard the OSG's call said that when she saw the man it was clear that he had been dead for some time. Rigor mortis was in an advanced state, his body was cold and there were other signs of death. She checked for a pulse but could not find one. She therefore decided not to attempt to resuscitate him. Two paramedics arrived at 5.22am and they too decided not to attempt cardiopulmonary resuscitation (CPR).
39. After a death, prison managers are expected to hold a "hot debrief" with all the staff involved to share information and support each other. Rather than gathering everyone involved, managers at Durham spoke to each member of staff individually and in pairs as they went off duty.
40. An officer went to the man's former cellmate's cell and broke the news privately to him. He told the investigator that the staff had given him a lot of support and the chaplaincy were keeping in touch with him. He said that the man had not said or done anything to worry him and that if he had, he would not have moved out of the cell. Officers went round the wing and told the other prisoners that the man had died. Staff held case reviews for all the prisoners on ACCT support plans.
41. The man had given his father as his next-of-kin but there were two different addresses in his record. The family liaison officers (FLO) went to both addresses but the man's father was at neither. They visited several addresses during the morning but were unable to contact his father. At 1.15 pm they met the man's mother and broke the news of her son's death. His mother called his father and left a message on his mobile telephone.
42. The following day, the man's father and uncle met the FLOs and chaplain at the prison. The FLOs explained the difficulty they had had in contacting him and then offered support, including a financial contribution towards the funeral.
43. The Buddhist chaplain held a service in memory of the man in the prison chapel on 2 May and his funeral was held on Friday 4 May. His former cellmate organised a collection in memory of the man.

ISSUES

Health

44. The clinical reviewer noted:

“[The man] was a prisoner who had minimal contact with prison Healthcare Staff. The contact he had would appear to have been appropriate and due care was provided.”

We agree with the clinical reviewer’s conclusion.

The man’s risk of self-harm

45. The clinical reviewer was satisfied that the assessments for alcohol withdrawal and self-harm carried out in reception were appropriate. With regard to self-harm, he states:

“Management of prisoner at risk of harm to self, to others and from others (Safer Custody) PSI 64/2011 indicates a number of potential risk factors which can predispose a prisoner to be at risk of self harm. Prisoners who have a history of violence, who lack family support, have a history of self harm and or substance misuse can provide a trigger for potential self harm. As can their situation in terms of the judicial process.”

46. The man had previous convictions for violence, and contact with his girlfriend, who was one of his victims, was stopped in January. He had a history of self-harm, but this was ten years earlier. He was on remand, facing charges of violence and had another court appearance at the end of the month. However, both an RMN and a doctor assessed him in reception. They said that during their consultations with him, he said and did nothing that caused them concern.
47. Although the security department staff removed the man’s access to his girlfriend’s mobile phone number and prevented him from sending letters to her, information from his cellmate and the letters found in his cell suggest that they appear to have been in touch through a mutual friend. He maintained contact with friends and family members with visits, telephone calls and letters. His cellmate told the investigator that the man was very fond of his dog and was missing him very much. The man’s telephone conversation with his father three days before his death showed that he was thinking about the charges he was facing.
48. The clinical reviewer, having looked at the various risk factors that may have been relevant to the man, concludes:

“It must be recognised that the benefit of hindsight provides unique insight to incidents such as this. There were potential risk factors present, but when taken as a whole it is speculative to attempt to determine the degree with which they contributed to the outcome and

there is nothing to suggest the care of [the man] was suboptimal [not good enough].”

49. We agree that while there were some risk factors which might have indicated some concern when the man first arrived at Durham, but there was little to indicate in April that he was at raised risk of suicide or self-harm.
50. His former cellmate told the investigator that the man never did or said anything to worry him. If he had thought there was anything at all, he would not have moved out of the cell.

Alleged threats to the man

51. The possibility that another prisoner was bullying or threatening the man was first raised by his cellmate when the investigator interviewed him. His cellmate said that he had heard that a prisoner on A wing was going to pay another prisoner to harm the man. He was unwilling to name the prisoner. His cellmate did not discuss the information he had with the man and did not know whether he was aware of it.
52. In her letter to the Governor, the man’s girlfriend said that the brothers had “tortured” and seriously bullied him. She said that the brothers had called him a paedophile. Although the investigator was told of rumours of bullying, she found no evidence that anyone had actually threatened, bullied or physically harmed the man. None of the staff or prisoners she interviewed had seen signs of bullying and he had not told any of them that he was being victimised or had received any threats.
53. The investigator spoke to two of the wing cleaners who had cells on B1 landing at the same time as the man. Cleaners spend a lot of the day working around the wing and often know a great deal about what is happening on the wing. She asked them if they had ever seen signs that the man was being bullied or had heard rumours about it. The first wing cleaner said that he had heard talk about bullying, about a week or so before the man’s death, related to the charges he was facing. He did not know who was involved and saw no sign of bullying. The second wing cleaner said that he had not heard any rumours. Neither had ever heard anyone calling the man a paedophile. They were very shocked at the man’s death, as was his former cellmate.
54. We have been unable to find any evidence that the man was bullied. Records relating to him, including those regarding healthcare and visits, have been analysed without suggesting any contact between himself and the brothers. This, together with the layout of the wings and their supervision, suggests that it is unlikely that there was any physical contact between the man and the brothers. While we cannot discount that threats were made through a third party we have found no evidence of this.

Emergency codes

55. Durham has a system of codes to alert staff to different types of emergencies. Code Yellow is used for burns, Code Red when someone is bleeding and Code Black is for someone unconscious or not breathing.
56. When the OSG discovered the man, he should have called for assistance by saying, "Code Black at cell B1-16." Instead, he called for Oscar 1 and Hotel 1 (the call signs of the night orderly officer and his assistant) to go to B1 landing. The night orderly officer, who was Oscar 1, asked him what had happened and the OSG then said it was a hanging.
57. A nurse heard the call and started towards the cell. When the OSG said it was a hanging she realised the seriousness of the situation and asked a colleague to bring emergency equipment to the cell. The fact that the code was not used did not delay the arrival of staff and equipment and in any event it was too late to help the man. But in emergency situations every second counts and codes are an efficient way to alert and summon staff. It is helpful for nurses in particular to know the type of injury they are going to treat as they can mentally prepare themselves as they go to the cell.
58. The investigator asked to see a copy of the instructions the OSG had for emergency situations, including opening cells at night. The suicide prevention co-ordinator showed her one of the "night packs" all night duty staff are given at the start of their shift. It is a loose-leaf folder with inserts setting out their duties during the shift. The section on calling for assistance did not mention the emergency codes.
59. The suicide prevention co-ordinator told the investigator that managers revised the procedures in 2010, but it appeared that the night packs had not been updated to reflect the introduction and subsequent revision of the codes. He added that he would ensure that the packs had the correct procedures put into them as soon as possible. On her next visit to Durham, he showed the investigator an updated night pack with clear instructions to staff to use the codes.
60. At the end of the first set of interviews, the investigator met the Governor. They discussed the importance of accurate instructions and training in emergency procedures. We are satisfied this has now been properly addressed.

Cut-down tools

61. Prison Service Instruction (PSI) 2006-32 "Cut-down Tools", which came into effect on 20 November 2006 states, "All unified and uniformed staff in closed and semi-open establishments must be provided with and carry on duty their own personal issue cut-down tool".
62. At Durham, officers have all been issued with cut-down tools but OSGs do not carry them as part of their everyday equipment. When an OSG begins a night shift he or she is issued with a knife, along with a set of emergency keys, a

radio and the night pack folder. The knife should be attached to the OSG's belt.

63. When the OSG discovered the man, he did not have his knife with him and had to go to the wing office to collect it. As with the calling for assistance, the delay in opening the cell because the OSG was not carrying his cut-down tool, did not affect the outcome for the man. However, in other circumstances such an unnecessary delay could have serious consequences. When a prisoner is discovered hanging, every second can be vital.

64. During her opening visit, the investigator read the OSG's report, written on the morning of the man's death, and discussed this with the Deputy Governor. A Governor's Notice to Staff, was issued on 20 June. It states:

"All members of staff who carry a cell key are reminded that they should be in possession of an anti-ligature knife and this should be worn at all times on duty."

65. We are satisfied that appropriate steps have been taken to ensure that staff have been suitably reminded of the importance of carrying cut down tools.

CONCLUSION

66. When the man was at Durham, a number of factors in his background could have indicated a risk of suicide and self-harm. He was charged with violent offences, including assaulting his girlfriend. He had a previous history of self-harm, and was looking at the possibility of a long sentence of imprisonment. His contact with his girlfriend was stopped at her request.
67. However, the self-harm took place as a teenager in the community and was very much in the past. He was assessed by both a registered mental health nurse and a doctor and neither raised concerns about him. He had restrictions placed on his contact with his girlfriend at her request but knew the reason for this request and he still managed to correspond with her. He had visits from and telephone conversations with family members and friends and family wrote to him, so he had their support.
68. The man did not leave a note explaining his actions, so we do not know what was in his mind when he took the action that led to his death. Those who knew him in the prison were shocked by his actions. Whether it was a carefully considered decision or a spur of the moment action, being in the cell on his own gave him the time and privacy he needed.
69. We conclude that the man's death could not have been predicted. When found, he had been dead for some time so could not be saved. We are satisfied that the prison has since rectified an omission in the guidance to night staff about the use of emergency codes and reminded staff of the importance of carrying anti-ligature knives.