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 a man at HMP Holme House in September 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 at HMP Holme House in September 2013. He had cut his jugular vein, causing a fatal loss of blood. He was 49 years old. I offer my condolences to his family and friends.

A clinical reviewer assessed the clinical care the man received in prison. The prison cooperated fully with the investigation.

The police arrested the man and a co-defendant on 17 September and subsequently charged them with murder. He was treated for alcohol withdrawal when he was in police custody and monitored further for alcohol withdrawal symptoms after he arrived at HMP Durham on 21 September. After two nights, the prison GP decided that he needed no further treatment as he had no physical symptoms of withdrawal. He was not assessed as a risk of suicide and self-harm at Durham, although some risk factors were noted.

On 23 September, the man transferred to Holme House so he could be kept separate from his co-defendant. The mental health team at Durham were due to see him, so alerted Holme House. The Durham safer custody team had planned to speak to him because of information on his escort record about the murder charge and a history of depression, but they did not alert Holme House about this after he moved.

The man was found dead in his cell during a routine roll check a few days later. He had made a deep wound to his neck and it was too late to save him. He had been due to appear at Crown Court the following Monday.

Some aspects of the man's care were reasonably good: the reception nurse at Durham appropriately referred him to the mental health team and to the drug and alcohol team and considered his risk of suicide and self-harm. He was checked regularly for symptoms of alcohol withdrawal while he was at Durham. After he transferred, the Durham mental health team ensured that their counterparts at Holme House were aware of him.

However, I am concerned that there was a lack of clear guidance for reception and first night staff at both prisons to ensure they understand their responsibilities for assessing the risk of suicide and self-harm. This task was left solely to the reception nurse at both Durham and Holme House. The Durham safer custody team did not share information with Holme House and mental health referrals at both prisons were not dealt with sufficiently urgently, which meant that the man was not assessed before he died. Finally, despite his murder charge, there was no evidence of structured support for him after he arrived at Holme House, a matter I have raised in the case of another recent death at the prison.

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

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

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SUMMARY

1. The man was arrested on 17 September 2013 and charged with murder. He was a heavy drinker and was given medication for withdrawal symptoms from alcohol while in police custody. On 21 September, he appeared in court with a co-defendant and was taken to HMP Durham. Because he was charged with murder and was dependent on alcohol, the reception nurse referred him to the mental health team and the GP. He declined a bed in the prison's inpatient unit. None of the staff in reception, including the nurse and GP, assessed him as at risk of suicide and self-harm. An induction officer who saw him after the reception processes did not discuss the murder charge with him or assess his risk of suicide or self-harm.

2. The drug and alcohol team checked the man over the next two days for symptoms of withdrawal from alcohol. Because there was information in his person escort record that he suffered from depression and had been charged with murder, a member of the safer custody team planned to see him. On 23 September, another GP saw him and was satisfied that he needed no further intervention for alcohol withdrawal as he did not appear to have any symptoms. The GP did not fully explain this decision in his medical record.

3. The man transferred to HMP Holme House later on 23 September, after the police asked that he and his co-defendant should be held in different prisons. Reception staff at Holme House did not identify that he was at risk of suicide. As the mental health team at Durham had not yet seen him, they passed this on to Holme House. The Durham safer custody team did not do likewise.

4. There is no record of prison or healthcare staff having any contact with the man on 25 or 26 September. Although Durham had telephoned and faxed a mental health referral on 24 September, the Holme House mental health team did not process this until 26 September. This meant that they did not see him before he died as they planned that someone would see him within the next two working days.

5. The man was locked up as usual a few days later. At about 5.10am the next morning, during a routine early morning roll check, a night patrol officer saw him apparently dead in his cell. He called for assistance and other officers and nurses attended quickly. They immediately identified that he was dead and resuscitation would not be possible. He had used a razor blade melted into a toothbrush to cut open a vein in his neck.

6. The man appears to have been appropriately monitored for symptoms of alcohol withdrawal at Durham and then discharged from treatment after nearly a week in police and prison custody. However, we do not consider that his risk of suicide and self-harm was properly considered by reception and induction officers at either Durham or Holme House and reception processes at both prison were insufficiently robust.

7. We consider that the safer custody unit at Durham should have indicated to their counterparts at Holme House that they had intended to see the man because of information on his original PER. Mental health referrals at both Durham and Holme House should have been processed with greater urgency.

8. There is little evidence that the man received any structured support after he arrived at Holme House. There are no checks on prisoners during their first nights at the prison unless they have been assessed as a risk of suicide or self-harm. There are few recorded interactions with him and none at all for the two days before his death. He had no contact with his family or friends while in prison. We do not suggest that every prisoner charged with murder should always be subject to suicide and self-harm monitoring, but the lack of any support for him for more than 48 hours before his death appears wholly inadequate for a newly arrived prisoner charged with murder.

9. We make four recommendations as a result of our investigation.

THE INVESTIGATION PROCESS

10. Notices were issued to staff and prisoners at HMP Holme House about the investigation. No one responded.

11. The investigator obtained the man's clinical and prison records. The Person Escort Record was missing from his reception documents at Durham.

12. The investigator interviewed staff at Holme House on 15 October and 6 November 2013 and staff at HMP Durham on 1 December 2013 and 22 January 2014. He interviewed a nurse by telephone on 7 February 2014. He gave written feedback to the Governors of Holme House and Durham.

13. Spectrum Community Health CIC appointed a clinical reviewer to assess the man's clinical care at the prisons.

14. We have sent the local Coroner a copy of this report.

The man's family

15. Our family liaison officer provided the man's family with a copy of the draft report. His family explained that they had found the report difficult to read and they thought that he should have been monitored more closely because of his circumstances.

HMP HOLME HOUSE

16. Holme House is a local prison for up to 1,212 men. The majority of its prisoners are remanded into custody or have been recently convicted by courts in the local area. The prison also holds a small number of young adults, aged 18 to 21. Care UK provides health services at Holme House. Nurses are on duty 24 hours a day.

Her Majesty's Inspectorate of Prisons

17. HM Inspectorate of Prisons most recently inspected Holme House in August 2013. Inspectors reported that the prison faced significant challenges but had made some important progress. However, they were concerned that previous progress made in learning about risk indicators associated with self-inflicted deaths had not been sustained. Care for prisoners who had been assessed as at risk of suicide or self-harm was good, but inspectors found that first night assessments were inadequate and were concerned that prisoners at risk of suicide and self harm would not be identified.

18. Inspectors found that there was a lack of private space in the reception area which inhibited newly-arrived prisoners from disclosing sensitive information. They also reported that first night cells were dirty and some of the worst they had seen. There was a lack of organised support for newly-arrived prisoners.

Independent Monitoring Board

19. Each prison has an Independent Monitoring Board of unpaid volunteers from the local community to help ensure that prisoners are treated fairly and decently. In their 2012 annual report, the IMB wrote that reception staff provided an efficient and effective service for newly-arrived prisoners.

Previous deaths

20. Four of the last five self-inflicted deaths at Holme House since November 2011 happened during the prisoner's first days in custody. Three involved men on the induction unit. After the death of a man in June 2012, two days after arriving at Holme House, we recommended that all known risk factors of newly-arrived prisoners should be fully considered. We also made similar recommendations about the need to consider all risk factors after the deaths of prisoners in July 2012 and September 2013.

HMP DURHAM

21. 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 Valleys NHS Trust.

Her Majesty's Inspectorate of Prisons

22. The last published inspection report of Durham was of an inspection in October 2011. The report of an inspection in December 2013 has yet to be published. In 2011, inspectors found there was a high rate of self-harm.

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.

23. Inspectors found that reception processes were efficient, but not all reception interviews were held in private. In 2011, inspectors found that first-night interviews were thorough and the quality of induction reasonable. However, we understand that in the more recent inspection in December 2013, one of the Inspectorate's main concerns was that first night procedures were not working effectively. Arrangements were fragmented and ineffective for many prisoners with a general lack of care. First night interviews did not always focus on vulnerability or risk.

Independent Monitoring Board

24. In its most recent published annual report (2012-13), the Durham IMB noted that 655 prisoners were placed on suicide or self-harm monitoring during the reporting year, more than 130 up on the previous year. The IMB considered that recent training had raised awareness of the purpose of suicide awareness and prevention.

KEY EVENTS

25. The man was born in September 1964. He had previous criminal convictions and had been to prison before, but not for over ten years. On 17 September 2013, he was arrested on suspicion of murder. He was a heavy drinker and was given diazepam (a benzodiazepine used to treat the symptoms of alcohol withdrawal) while he was in police custody from 17 September until 21 September.

HMP Durham

Saturday 21 September 2013

26. The man and a co-defendant were charged with murder. On 21 September, they appeared at Magistrates' Court and were remanded into custody after their case was committed to Crown Court. Both co-defendants were taken to HMP Durham. They arrived at about 1.30pm, but were kept separate throughout the reception process.

27. In reception, an officer assessed the man as a high risk for cell sharing because of the murder charge. An officer recorded his arrival on the electronic prisoner record system. Neither officer spoke to him about thoughts of suicide or self-harm. (We were told that this was not regarded as part of their responsibilities.)

28. A nurse and a healthcare support worker then saw the man in a private room in the reception area. He said that he was not prescribed any medication and had no outstanding medical appointments. He told them that he drank 100 units of alcohol each week and had more than 10 alcoholic drinks each day. He said that he was experiencing alcohol withdrawal symptoms but the nurse did not observe any during the assessment. His urine tested positive for benzodiazepines (likely to have been because of the diazepam which he had been given at the police station) and cocaine which he admitted using.

29. The nurse said that the man seemed to be in a state of shock, but he answered all of her questions, which included standard enquiries about suicide and self-harm as part of the first night electronic clinical screening assessment. She told the investigator that he looked very surprised when she raised the idea of suicidal thoughts. He said that he was not going to harm himself and had not previously tried to harm himself either in prison or the community. He said that he had not been treated for psychiatric problems in the community. (It does not appear that the nurse saw his Person Escort Record which identified that he had been diagnosed with depression.) She told the investigator that there was nothing remarkable or especially concerning about his mood and behaviour, other than his charge of murder. She said that she would have started suicide and self-harm monitoring if she had had any concerns that he was having suicidal thoughts.

30. The nurse knew that a charge of murder heightened the risk of suicide and self-harm and referred the man to the mental health team. She told the investigator that she always did this for prisoners charged with murder. She offered him a place in the prison's inpatient unit for monitoring because of possible alcohol withdrawal and because he had been charged with murder.

He firmly declined. She referred him to the Drug and Alcohol Recovery (DART) team for alcohol withdrawal treatment and referred him to the reception GP for medication.

31. A doctor saw the man, who said that he drank everyday from morning until night and got the shakes if he stopped drinking. He said that he had drunk 20 cans of lager a day for years and had been experiencing shakes and hot and cold sweats. She observed him, who seemed calm and was not shaking, sweaty or restless. She noted that he had been given diazepam several times each day at the police station since his arrest.

32. The doctor did not think that the man was experiencing alcohol withdrawal symptoms. As there is no GP in the prison on Sundays, she prescribed chlordiazepoxide for staff to issue to him if he developed symptoms of alcohol withdrawal the next day. She prescribed 24 capsules; two would normally be given every four hours if staff observed symptoms.

33. The man was taken to E wing, the first night, induction and stabilisation wing. He had a brief induction interview with an officer. The officer told the investigator that he could not remember speaking to him. He estimated that his usual induction interview with a prisoner takes about a minute. He told the investigator that he did not ask about suicide and self-harm because he was not prompted to do so by the part of the 'First night, induction and initial assessment' form which he is obliged to complete. The officer explained that he usually gives a prisoner tobacco if he smokes, provides him with a telephone PIN number and answers any questions he might have about life on the wing. Afterwards, he was moved to B wing, so he would be apart from his co-defendant, who had been located on E wing.

Sunday 22 September

34. Officers did not check the man during his first night in prison on B wing and there are no routine checks for first night prisoners on E wing, the usual induction unit, either. However, a nurse from the DART team monitored him twice during the night. He got some sleep and told her that he felt well. She did not observe any alcohol withdrawal symptoms and decided that he did not require chlordiazepoxide.

35. Later that morning, two healthcare support workers (HCA) from the DART team saw the man in a side room on B wing for about ten minutes. He seemed nervous and his arms were shaking a little. One HCA noticed that he looked very thin and undernourished. He said that he was nervous about facing a charge of murder rather than about being in prison. He said that he was a 'massive drinker' and consumed more than 60 units each day. She thought that he was probably suffering from nerves rather than alcohol withdrawal. However, she was unsure whether he needed to be given chlordiazepoxide and asked a nurse to check him.

36. The man told the HCA that he was not having any thoughts about suicide or self-harm. She told the investigator that there was nothing about his mood and behaviour which would have prompted her to begin suicide and self-harm monitoring. However, she made another referral to the mental health team as a precaution.

37. The nurse checked the man after he saw the HCA. She told the investigator that he was not exhibiting any withdrawal symptoms at the time so she did not give him any chlordiazepoxide. She made an entry to this effect in the clinical record.

Monday 23 September

38. Monday, 23 September was the man's birthday. A doctor assessed him during his morning drug and alcohol clinic. The HCA was present during the assessment. The doctor noted that he had been drinking heavily until he was arrested by the police a week before. He said that he had last had a drink on 16 September. He reported prolonged alcohol dependency and said that he normally woke up shaky and sweaty and drank 20 cans of five percent strength lager each day.

39. The man engaged in conversation but showed very little emotion. His mood was blank. He seemed neither agitated nor low and depressed. He said that he was not having any suicidal thoughts. The doctor completed a GP mental health assessment because of his blank presentation but found nothing to suggest serious mental health problems. He confirmed that the man had already been referred to the mental health team.

40. The doctor found no evidence of alcohol withdrawal symptoms such as sweats, tremors, restlessness or agitation and therefore did not prescribe the man any medication. Because he had no withdrawal symptoms after seven days in police and prison custody, the doctor planned no further treatment or monitoring and was satisfied that he required no further intervention for alcohol withdrawal.

41. The HCA made an entry in the clinical record after the doctor had seen the man. This stated that he had been discharged from clinical monitoring and that there was no further action required from the DART team. She told the investigator that he had looked nervous and timid during the appointment, but she did not believe that he needed to be monitored under suicide and self-harm prevention procedures.

42. At about 2.00pm, a member of the security department checked the man's PER for any pertinent information, as is routine for new prisoners at Durham. She informed the safer custody team that the PER indicated that he suffered from depression and had been charged with murder. This information was logged on a safer custody database and internal safer custody enquiry form. The enquiry form would normally prompt a member of the safer custody department to assess him within seven days.

HMP Holme House

43. The man transferred to Holme House at the request of the police later on 23 September and arrived at about 5.30pm. The Person Escort Record (PER did not highlight any concerns about suicide or self-harm and did not contain the information that he suffered from depression which had been on the original PER.

44. A primary care agency nurse who had previously worked permanently at Holme House, carried out a first night health screen. Before she saw the man, she had looked at the electronic patient record system and had read the doctor's entry from earlier that day. She noted that he had not used alcohol for a week and that the doctor had recommended no further action was required. She advised the Holme House reception GP that he would not need to see him because a doctor had already discharged him from any further monitoring earlier that day.

45. The nurse told the investigator that nothing stood out about the man during the health screen. She could not recall whether or not she had known about his murder charge at the time, but she knew that he had been transferred from Durham to be kept away from his co-defendant. The charge was written on his PER, but we do not know whether this was given to the nurse.

46. The man told the nurse that he was not having any thoughts about suicide or deliberate self-harm. He seemed relaxed and there was nothing at all about his presentation which suggested to her that he might take his own life. She did not think that ACCT monitoring was necessary based on his mood and behaviour in reception.

47. The man said that he had been diagnosed with depression a few months earlier but had not yet been prescribed any medication. She did not make a mental health referral. She noted from the doctor's entry that a mental health referral had already been made at Durham. She knew that this would be passed on to the mental health team at Holme House because this is standard procedure.

48. The nurse recorded no concerns about the man's physical and mental health. He asked to see the optician, and this was the only referral she made for him. She noted in the clinical record that she had advised him how to access sources of support if his feelings changed.

49. An officer completed a cell sharing risk assessment (CSRA) and induction interview with the man in reception. He said that he would prefer a single cell. The officer referred his CSRA to the duty governor for authorisation because he had assessed him as a high risk to other prisoners because of his alleged offence of murder. She decided that he was high risk and should not share a cell for the first 48 hours. She recorded on the CSRA that he would be reviewed after two days and, if he was then assessed as suitable to share, he should only be located with a long term prisoner. A second CSRA was not completed two days later as she had planned.

50. The officer could not remember interviewing the man when he spoke to the investigator. There is no question on the induction interview form about thoughts of suicide and self-harm, so it seems unlikely that he asked him about this. However, the officer recorded that the man had no immediate concerns or worries and was aware of his remand status and the charge against him.

51. The man moved into cell 7 on the second landing of B wing on Houseblock 4, the induction unit. This is a single cell. He was not assessed as a risk of suicide and self-harm so was not monitored.

Tuesday 24 September

52. The next morning, the man completed the induction process. He was told how to speak to the Listeners (prisoners trained by the Samaritans to support other prisoners in distress).

53. The same morning an administrator at Durham processed the nurse's mental health referral for the man and realised that he had now transferred prisons. She contacted Holme House mental health team by telephone and passed the information to a mental health nurse. Staff also faxed a mental health referral to Holme House the same day.

54. At 10.00am that morning, the man appeared at Crown Court by video link and his case was adjourned until 30 September.

Wednesday 25 and Thursday 26 September

55. There is no record of any checks being made on the man or him attending any appointments on either 25 or 26 September.

56. On 26 September, a nurse from the mental health team noted on the man's clinical record that they had received a faxed referral for him from Durham. She noted that he should be seen within two working days, meaning either Friday 27 or Monday 30 September.

57. An officer told the police that he locked the man in cell B2-07 at about 7.10pm that evening. At the time, there were no concerns about him and he appeared fit and well.

Events of the incident

58. The nurse who worked the night shift on Houseblock 4 throughout the week and was responsible for monitoring any prisoners withdrawing from alcohol or drugs said he had not been asked to check the man since he arrived and had not treated or spoken to him.

59. The man did not press his cell bell during the night. A night patrol officer began his usual roll check of A, B and C wings at about 5.00am. He checked prisoners on the third landing of all three wings first, then the second landing of C wing, before reaching B2 landing.

60. At about 5.10am, the night patrol officer looked through the observation panel of the man's cell door and switched the light on. He saw him lying fully clothed on his bed. His mattress was soaked in blood and there was a large amount of blood pooled around his neck. He could clearly see a wound to his neck and thought that he was dead. He radioed a code red emergency to indicate a life threatening emergency where a prisoner is bleeding. The control room requested an emergency ambulance within a minute.

61. The officer ran to the night patrol office and told the assistant night orderly officer (NOO) and an officer who was the night patrol officer on Houseblock 4, what had happened. The two officers went immediately to the cell, while he

went to find the nurse. The NOO unlocked the cell and went in and saw that the man had cut his throat. He observed no signs of life.

62. The nurse was in a treatment room near the night patrol office when he heard the code red message and immediately collected two emergency response bags from the nearby smaller clinical office. The nurse met the night orderly officer as he went along the landing, went into the cell and checked the man. He had made a large wound to the left side of his neck using a razor blade melted into a toothbrush. There was a considerable amount of blood soaked into the mattress but he was no longer bleeding. He was not breathing, his pupils were fixed and dilated, his arm was cold and his jaw was stiff. The nurse did not attempt to perform cardiopulmonary resuscitation because it was clear that he was dead. He surmised that he had died one or two hours earlier.

63. More staff arrived. Another nurse checked the man and agreed with the first nurse that he had been dead for some time and that they should not attempt resuscitation.

64. An ambulance arrived at the prison gates at 5.36am. An officer escorted the paramedics and they reached the wing at 5.45am and immediately pronounced the man dead. At about 7.00am, managers held a debrief meeting on Houseblock 4 for staff involved in the incident to offer them support. One of the prison GPs attended the cell at 8.26am when he arrived for his usual day shift and certified death.

65. The man did not leave any note in his cell. Two family liaison officers visited his partner to break the news. The family liaison officers then went to his parents' home a short while later and told them. The prison contributed towards the cost of the funeral in accordance with Prison Service policy.

66. The post-mortem investigation found that the man had made two incisions to his neck. The first was minor, but the second severed the jugular vein, causing a fatal loss of blood. He had used a blade from a disposable razor which was melted onto the end of a toothbrush. The toothbrush with the blade still attached was found in the sink within his cell. A trail of blood led from the sink to the bed on which he was found.

ISSUES

Alcohol withdrawal

67. Before arriving at Durham, the man had already spent four days in police custody, where he had been prescribed diazepam for alcohol withdrawal symptoms. At Durham, a doctor prescribed chlordiazepoxide as a precaution in case he exhibited further symptoms, but the Drug and Alcohol Recovery Team (DART) nurses did not consider that he required any medication at any time. Prison Service Instruction 45/2010 about the Integrated Drug Treatment System requires all drug or alcohol dependent prisoners arriving in reception to be offered immediate admission to a stabilisation unit. Newly arrived prisoners withdrawing from alcohol or drugs at Durham usually stay on E wing for a period of stabilisation. However, he had to be held separately from his co-defendant who was also on E wing, so he was located on B wing. Nevertheless, arrangements were made for DART nurses to monitor him on B wing and he was able to attend the doctor's clinic on E wing on Monday morning.

68. After two days at Durham, the doctor (a GP with a special interest in drug and alcohol treatment) was satisfied that the man was not exhibiting any withdrawal symptoms and discharged him from any further clinical monitoring. Although he reported very heavy alcohol misuse in the community, he had been in custody for almost a week when the doctor discharged him. He then transferred to Holme House, where no further treatment was offered and he did not see a GP. We are satisfied that he was properly monitored for alcohol withdrawal symptoms by the DART team at Durham and that the doctor made an appropriate decision to end monitoring when it was clear that he had no symptoms that required clinical treatment.

Mental health

69. A nurse referred the man to the mental health team at Durham on Saturday 21 September. Unfortunately, a request from the police to keep him separate from his co-defendant meant that he transferred to Holme House on Monday 23 September. The mental health team at Durham processed the nurse's referral on Tuesday 24 September, realised he had transferred and referred him to their counterparts at Holme House the same day by telephone and fax. However, the clinical record indicates that this subsequent referral was not actually processed by the Holme House mental health team until Thursday 26 September a delay of a further two days. He was then due to be seen by a mental health nurse at Holme House within two working days after that.

70. The early days in custody are a critical period for any prisoner, particularly one facing a very serious charge like murder. Although the man did not exhibit any psychosis or signs of a mental illness, he had been diagnosed with depression and was facing a charge of murder. We are concerned that it took two working days at both Durham and Holme House to process a mental health referral after it had been made. The transfer to Holme House was unavoidable but caused further delay. This meant that he was unlikely to have been assessed by a mental health nurse, until over a week after his arrival, despite a referral on the day he arrived. We make the following recommendation:

The Heads of Healthcare of Durham and Holme House should ensure that mental health referrals for newly arrived prisoners charged with serious offences are not delayed and the prisoner is seen no later than two days of a referral being made.

Assessment and management of risk of suicide and self-harm

71. Prison Service Instruction (PSI) 74/2011, which sets out procedures for early days in custody, requires all new prisoners to have a medical assessment. At Durham, a nurse assessed the man in reception. She identified that he was withdrawing from alcohol, although he had no obvious symptoms at the time, and that he was facing a murder charge. Otherwise, she found him to be an unremarkable prisoner. She did not assess him as needing to be monitored as a risk of suicide or self-harm. However, she offered him a place in the inpatient unit and made a number of referrals to ensure that his needs would be addressed during his early days in custody. She referred him to the mental health team as a matter of routine because of the murder charge. It does not appear that she was aware that he had been diagnosed with depression. We believe that the nurse took a considered approach to his care.

72. At Holme House, a nurse had no serious concerns about the man in reception and did not think that he needed to be monitored as a risk of suicide and self-harm. She did not refer him to a GP as she noted that a doctor at Durham had already discharged him from alcohol withdrawal treatment. He mentioned to her that he had been diagnosed with depression and she believed that this would be covered by the outstanding mental health referral. She ensured that he was aware of sources of support if his mood changed.

73. The nurses at both prison receptions completed their assessments and considered options to support the man. However, our investigation demonstrated that the nurses were effectively given sole responsibility for the assessment of the risk of suicide and self-harm and this was not considered by anyone else – including the first night induction officer at Durham. We are concerned that other staff did not see this as part of their responsibility. While both nurses were competent to assess his risk of suicide and self-harm it is often the case in prison receptions that healthcare staff do not have all the information about a prisoner and their risk factors on which to base a fully considered assessment of risk. There were no clear local procedures at either Durham or Holme House to require prison reception and first night staff to actively identify risk factors based on checks of relevant documents such as the Person Escort Record and other available information.

74. PSI 74/2011 requires new prisoners to be interviewed in reception to assess the risk of self-harm. We do not consider that any of the officers the man saw when he arrived at Durham assessed his risk of suicide and self-harm. An officer spoke briefly to him and recorded his arrival on the electronic prisoner record system. The officer completed the cell sharing risk assessment. Neither of these interactions constituted an induction interview or an assessment of his risk of suicide.

75. The officer who completed the man's induction interview at Durham could not remember him when he spoke to the investigator, but was quite clear that the interview would not have lasted any longer than a minute. He explained that he does not ask prisoners about suicide and self-harm because the 'First night, induction and initial assessment' form (a local Durham document produced in July 2012) only prompts the reception nurse to do so. He did not see it as part of his responsibilities to assess a newly arrived prisoner's risk of suicide and self-harm. We note that the recent inspection of Durham was critical that first night induction officers did not assess vulnerability.

76. The reception officer at Holme House could not remember the man when he was interviewed, or whether he asked him about suicide and self-harm. (None of the staff we interviewed at either prison could remember much about him. All his interactions with staff were unremarkable and he seems to have been a compliant prisoner who raised no significant concerns with anyone.) The local induction interview sheet (last updated in 2008), which the reception officer completes for every new prisoner, did not require the officer to ask about suicidal thoughts. We were recently critical of this outdated guidance for reception officers following another investigation of another death at Holme House a few days before his. In both cases, the reception process relied too heavily on the nurse to assess the risk of suicide and self-harm. We make the following recommendation:

The Governors of Durham and Holme House should produce clear local guidance about procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them. In particular this should ensure that reception and first night staff:

- **Have a clear understanding of responsibilities and the need to share all relevant information about risk.**
- **Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms, PERs and other sources.**

77. On Monday 23 September, Durham security staff checked the information on the man's Person Escort Record (PER) (which is now missing from his prison record). This check is standard for new prisoners. They passed relevant information to the safer custody department at 4.00pm the same afternoon. This prompted an officer to fill in a safer custody enquiry form, recording that he suffered from depression and was facing a murder charge. After an enquiry form is completed, a member of the safer custody team is expected to assess the prisoner within seven days. This process acts as an extra check on prisoners whose risk factors make suicide and self-harm more likely, but who will not necessarily have been identified as needing monitoring under suicide and self-harm prevention procedures when they first arrived.

78. The man transferred to Holme House that afternoon and the Durham safer custody staff took no further action. The officer explained to the investigator that he did not contact the safer custody team at Holme House because he assumed that they would gather the same basic information about his murder charge and depression during their reception process. This was not necessarily the case and it does not appear that Holme House had the

original PER. It would have been good practice for the safer custody team at Durham to telephone their counterparts and alert them to his arrival. If the potential risk information is worth recording in the first place, it is surely worth passing on. We make the following recommendation:

The Governor of Durham should ensure that, when a prisoner transfers, any outstanding concerns about suicide and self-harm are communicated by the safer custody team to the receiving prison.

79. The man was due to see the Holme House mental health team following a referral from Durham, but was no longer being monitored for alcohol withdrawal. It is particularly stark that there is no evidence that he had any meaningful interaction with staff on 25 or 26 September. Like another prisoner whose suicide we investigated recently, he arrived on the induction wing and then received little or no further input. This was an inadequate level of monitoring and interaction for any newly arrived prisoner but was particularly so for a prisoner charged with murder. While we do not consider that suicide and self-harm monitoring is needed for every prisoner charged with murder, there is no evidence in either his clinical record or his electronic prison record that staff were checking on his welfare during his first few days with them, or had any plan to do so. We make the following recommendation:

The Governor of Holme House should ensure that newly-arrived prisoners are given structured support during their early days in custody to ensure their wellbeing.

Emergency response

80. The clinical reviewer comments in his clinical review that the emergency response appears to have been promptly and efficiently undertaken. We agree that staff responded quickly and appropriately but that nothing could have been done to save him, who was clearly dead.

RECOMMENDATIONS

1. The Heads of Healthcare of Durham and Holme House should ensure that mental health referrals for newly arrived prisoners charged with serious offences are not delayed and the prisoner is seen no later than two days of a referral being made.

2. The Governors of Durham and Holme House should produce clear local guidance about procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them. In particular this should ensure that reception and first night staff:

    - Have a clear understanding of responsibilities and the need to share all relevant information about risk.
    - Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms, PERs and other sources.

3. The Governor of Durham should ensure that, when a prisoner transfers, any outstanding concerns about suicide and self-harm are communicated by the safer custody team to the receiving prison.

4. The Governor of Holme House should ensure that newly-arrived prisoners are given structured support during their early days in custody to ensure their wellbeing.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	**HMP Durham and HMP Holme House** The Heads of Healthcare of Durham and Holme House should ensure that mental health referrals for newly arrived prisoners charged with serious offences are not delayed and the prisoner is seen no later than two days of a referral being made.	Accepted	**Holme House** Prisoners arriving at HMP Holme House with outstanding mental Health referrals from other establishments will be referred to Holme House Mental Health services immediately and will be seen within 48hrs. Mental Health operational policy will be amended to ensure all prisoners arriving at Holme House charged with serious offences will be referred for a mental health assessment. **Durham:** Interviewing prisoners from Mental Health Referrals within 48 hours is a KPT for the current provider (Tees, Esk and Wear Valleys NHS Foundation). Performance against target is reviewed during regular meetings between Head of Res & Safety and the Mental Health Team manager. Referrals for those charged with Serious Offences will be introduced by 1st May 2014.	31st May 2014 31/05/14	
2	**HMP Durham and HMP Holme House** The Governors of Durham and Holme House should produce clear local guidance about procedures for identifying prisoners at	Accepted	**Holme House** A system of annual reminders of staff responsibility with regard to the management of self-harm warnings has been put in place. A Governors Order has been circulated describing areas of risk to consider, this will be issued yearly to all staff, including those working in healthcare and Mental health.	Complete	

	risk of suicide and self-harm and for managing and supporting them. In particular this should ensure that reception and first night staff: a) Have a clear understanding of responsibilities and the need to share all relevant information about risk. b) Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms, PERs and other sources.		All relevant departments (Safer Custody; Health care ;Mental health; Reception; Video Link; Custody Office; Offender Management Unit; Residential; First Night Centre and Induction) have been made aware that all newly arrived prisoners are at a heightened risk of suicide/self-harm. **Durham:** Information regarding known risk factors is now displayed in prominent positions throughout the Reception area. All reception staff have been made aware of their responsibility with regard to ACCT procedures and the importance of opening ACCTs for appropriate high risk prisoners. Induction/Resettlement interview sheet has been amended to include information about risk and information sharing. New sheets will be in place as soon as print run has taken place.	Complete Complete Complete 30th April Durham: 30/04/14	
3	**HMP Durham** The Governor of Durham should ensure that, when a prisoner transfers, any outstanding concerns about suicide and self-harm are communicated by the safer custody team to the receiving prison.	Accepted	A system of advising receiving establishments about any Safer Prisons concerns regarding transferring prisoners is now in place. Safer prisons staff provide information to their counterparts in the receiving establishment.	Complete	
4	**HMP Holme House**	Accepted	In November 2013 HMP Holme House introduced the prisoners Engagement	Complete	

	The Governor of Holme House should ensure that newly-arrived prisoners are given structured support during their early days in custody to ensure their wellbeing.		Programme. Once a prisoner has completed their prison induction, they will be allocated by the Activity Management Unit (AMU) to the Engagement Programme. This is a rolling programme, lasting two weeks. The purpose of the programme is to provide an introduction to the opportunities available to all throughout their sentence, to help towards fulfilling sentence plans and reducing re-offending. The programme also provides prisoners with the opportunity and support to effectively resettle and gain sustainable employment upon release.		