

Investigation into the circumstances surrounding the death
of a man at HMP Holme House
in November 2005

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

January 2007

This is the report of an investigation into the death of a man died at HMP Holme House on 20 November 2005. He was found hanging from the pipes under the sink in his single cell early that morning. The man was 33 years of age.

I would like to offer my sincere condolences to the man's family for their loss and must also apologise for the delay in producing this report.

The investigation was conducted on my behalf by two of my investigators. In the company of a Family Liaison Officer from my office, my investigator also met with the man's brother to discuss the investigation and the questions the family wanted answered.

I thank the deputy governor of Holme House who was temporarily in charge of the prison at the time of my investigation, for her and her staff's assistance. I am particularly grateful to a member of the prison staff who acted as the local liaison officer. Thanks are also due to the Clinical Governance Lead for North Tees Primary Care Trust, who conducted a clinical review of the man's healthcare needs and how they were met.

Originally from Asia, the man had been in Holme House for less than three weeks when he was found hanging. Every effort was made to save him and I commend the staff for their efforts. However, I have found several shortcomings in the way staff dealt with the man's needs as a foreign national, and how they responded to his treatment from other prisoners.

I make six recommendations.

Stephen Shaw CBE
Prisons and Probation Ombudsman

January 2007

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SUMMARY

The man was remanded into Leeds prison in early October 2005. Within two weeks, he had been moved to the vulnerable prisoner unit for his own protection. This was due to his receiving multiple threats from other prisoners. The man was deemed as especially vulnerable due to his poor English and lack of knowledge of prison life.

In early November, the man appeared at the Crown Court where he appeared particularly depressed and upset. The custody officer opened a suicide/self harm warning form to alert prison staff. The man was remanded into Holme House prison where a nurse discussed the reasons for his being upset. He said that he was saddened that he was separated from his wife and child, but was clear that he had no thoughts of harming himself.

After two nights on the first night centre, The man was moved to houseblock 4. The man who subsequently died was well known to staff and prisoners, as he was often demanding of their time. He pressed his cell bell frequently, often asking to see Listeners (prisoners trained by the Samaritans). The man also often made a lot of noise by banging on the pipes in his cell which disturbed the other prisoners on the wing.

At times, the man could appear over-exuberant, and staff had seen him dance and sing in return for cigarettes from other prisoners. Staff were of the opinion this was in jest, and the man did not appear to mind. I am disappointed that staff did not identify this as bullying behaviour and make a recommendation on this matter.

In mid November, whilst taking exercise outside, it came to an officer's attention that the man had been heard asking other prisoners about methods to self harm. The officer passed this information to the wing Senior Officer. The Senior Officer discussed it with the man who categorically denied any conversation with others about self-harming.

The following day, an officer found a noose concealed in the man's pillowcase. The officer appropriately opened a self-harm support document. The same day, the man was assessed both by a Senior Officer, also the safer custody officer, together with the wing Senior Officer. The man emphatically denied any thoughts of self harm, and claimed that other prisoners might have planted the noose in his cell.

The man continued to deny any thoughts of self harm at his self-harm review in mid November, and convinced the staff that he had no suicidal ideation. The review panel was an experienced one, including a psychologist, mental health nurse, the safer custody officer, and a wing Senior Officer.

The same day, the man's cellmate moved cells after complaining he could not cope with the man's behaviour any longer. The man who died had been waking him in the night to ask him questions and continuously banging on

pipes. Another prisoner shared a cell with the man for one night before complaining about the same problems. The man was therefore placed in a single cell.

Over the next couple of days, the man's constant noisiness resulted in prisoners shouting abuse at him and making threats. Staff felt they could no longer guarantee his safety on the wing and decided he should be moved to the vulnerable prisoner unit on houseblock 3 for his own protection.

The man moved to the vulnerable prisoner unit on or around mid November. Staff on houseblock 3 recalled that the man repeatedly asked questions about the length of sentence he might receive, and about any potential involvement from the Immigration Service. The man continued to press his cell bell a great deal, and made a lot of noise in his cell. Staff reported that he seemed anxious, but not depressed or suicidal.

On two consecutive dates on or around mid November, the man made several phone calls to his niece. He sought reassurance about the sentence he might receive, and asked about the welfare of his daughter. In his last call, he cried when he spoke of his daughter but told his niece he would call later.

The last known contact with the man was when, on the aforementioned second consecutive date around mid November, he asked a prisoner in the cell next door for a cigarette at about 11.30pm. The following morning, he was found suspended by a ligature tied to the pipes under his sink in his cell. Valiant attempts were made to resuscitate him, but to no avail and he was pronounced dead at 6.35am.

The man was vulnerable in many ways. He lacked understanding of prison life and what might upset other prisoners. It is possible that he was suffering from mental illness, but he refused assessment. The man was also upset about not having contact with his daughter. In addition, he had suffered a great deal of family bereavement in recent years, was often concerned about the sentence he might receive, and was concerned that he would come to the attention of the Immigration Service. He had a poor command of English, and it is likely that he may not have been able to fully express how he felt and what he needed. On top of this, the man was verbally bullied by some other prisoners.

My investigation found that staff at Holme House appeared to lack a full understanding of the needs of foreign nationals, and were not proactive in their approach. This was compounded by the absence of a foreign national policy and foreign national coordinator. There was an over-reliance on the race relations officer. He was committed and able, but was only allocated eight hours a week to complete his work and did not have the high profile within the establishment of the safer custody officer.

Staff did not use their radios on finding the man, but instead used telephones to communicate. Whilst I do not feel the outcome was affected in any way, in another case time could be of the essence. I make a recommendation about this matter.

Attempts at resuscitation were made in very trying circumstances. I have recommended that actions of the staff concerned should be formally recognised.

THE INVESTIGATION PROCESS

1. I appointed a member of my investigation team to lead the investigation on my behalf. The investigation team visited HMP Holme House where they met the in charge Governor and visited the cell where the man had been found. They met with members of the local branch committee of the Prison Officers' Association (POA) and the Independent Monitoring Board (IMB).
2. Notices were issued to both prisoners and staff, inviting anyone who might have information relating to the man to make themselves known to the inquiry.
3. Along with my Lead Investigator, one of my Family Liaison Officers, visited the man's brother to ascertain any particular family concerns and questions about the investigation. The brother's main concern was that the man who died had been in a single cell at the time of his death.
4. The investigation team interviewed prison staff and prisoners, both formally and informally. The team examined the man's prison record, medical records and a series of prison documents. They also assessed the care that he received against Prison Service standards, orders and policies.
5. A clinical review of the man's healthcare whilst in prison custody was undertaken by a Medical Practitioner from North Tees Primary Care Trust.

6. The man was born in Asia in 1972. He had been part of a large family, but the political unrest in his country had made it a difficult place in which to grow up and live. The man's brother told my investigators that several years prior to the man's death, a number of their family members had died in a bombing. This had deeply affected the remaining family members. Together with his wife, brother, sister and her immediate family, the man was granted asylum in the UK.
7. The man's brother described him as having a pleasant disposition, but he knew that the man was distraught at not having contact with his daughter. He explained that the man might have been quite fearful of prison, and would not know what to expect. He said that the man's solicitor was working on getting him released on bail, and was hopeful that, if successful, the man would live with his brother in London.
8. One of the man's friends had taken his own life some months earlier. The man's brother recalled that the man had said that he could not understand why someone would take their own life.

HMP HOLME HOUSE

9. Holme House is situated in Stockton on Tees, Cleveland, and is a category B local prison for unconvicted, convicted and sentenced male adults. The prison primarily serves the communities of Tees Valley, South West Durham, East Durham and North Yorkshire. The prison opened in May 1992 and its operational capacity (the maximum number of prisoners who can be held there) is 994.
10. Ms Anne Owers, Her Majesty's Chief Inspector of Prisons, inspected Holme House in April 2005. In the introduction to her report, Ms Owers wrote that the prison had taken positive steps forward, and was largely safe and well ordered with some pockets of excellent work. She added that "suicide and self harm prevention was well managed; and more prisoners told us that they felt safe in Holme House than in comparable establishments." She also reported better than average relationships with the staff. However, Ms Owers was concerned by examples where staff seemed to marginalise some minority groups such as foreign nationals. Ms Owers observed that "staff seemed to respond to requests from these groups, rather than actively checking that their needs were met."
11. At the time of Ms Owers's inspection, there was no foreign nationals policy at Holme House and this became a main recommendation of her report. Some six months after the inspection at the time of this investigation, there was still no policy in place and I have repeated the recommendation.
12. In the section of her report dealing with self harm and suicide, Ms Owers wrote that five prisoners committed suicide in 2002 while at Holme House. She noted that Holme House had been one of the pilot sites for the Prison Service's new Assessment, Care in Custody and Teamwork (ACCT) approach to managing prisoners at risk of self harm. She observed approvingly that the Mental Health In Reach Team had run sessions for staff and Listeners (prisoners trained to assist their fellow prisoners at times of crisis) to raise awareness of mental health issues.

KEY EVENTS

13. The man was remanded into Leeds prison in early October 2005 as a result of breaking the restraining order preventing contact with his wife. He did not settle well in Leeds. According to staff entries in his wing history sheet, he was disruptive in education classes and sometimes tearful and concerned about his family. They described his behaviour as erratic and he 'annoyed' other prisoners. This led to the man being bullied by some. On 18 October, staff were so concerned about the man's safety on the wing that he was moved to the vulnerable prisoner wing under prison rule 45. (Rule 45 is a rule that allows a prisoner to move to a wing which holds those who find it difficult to cope with prison life, or who for other reasons do not feel safe in the general prison population). The governor who authorised the move said, "the man has been subjected to serial bullying by many prisoners due to his lack of English, small stature and lack of prison life. Especially vulnerable."
14. On 3 November, the man appeared at a Crown Court where he was again remanded into prison (this time to Holme House). Whilst in the court cells, the man was crying and appeared very depressed. The Custody Officer, asked the man why he was so upset and he said that his wife was taking his children away. The Custody Officer became concerned by the man's behaviour and appropriately opened a suicide and self harm warning form. (This form is opened by the escort service staff if they have concerns. The form is then passed onto prison staff to alert them to a prisoner's demeanour. It is the prison staff who then make the decision as whether to initiate formal suicide and self harm monitoring using the Assessment Care in Custody Teamwork (ACCT) process.)
15. Later that day, the man arrived at Holme House where he went through the various reception screening processes. A nurse recorded in his medical records that the man had been seen, but he did not undergo a full healthcare assessment as he had in effect been transferred from another prison. The nurse spoke to the man about his emotional state whilst at court. The man told the nurse that he had been crying because he had lost his family. He denied any thoughts of suicide or self harm. The nurse felt it was not necessary for the man to be subject to the ACCT procedures. The nurse then weighed the man and recorded that he had no medical problems.
16. Officer A completed a "prisoner reception checklist". It was noted that the man had no immediate concerns. Staff had explained rule 45 to him, but he had declined the opportunity to take vulnerable prisoner status at this stage. The checklist also noted that English was not the man's first language and his command of it was poor. The man said he was Hindu. Officer A completed a cell sharing risk assessment, and assessed the man as being of low risk if sharing a cell with another prisoner.

17. The man then spent his first two nights on the first night centre, where he was given a shared cell with another prisoner. It is not clear who this prisoner was, other than he was also Asian.
18. The following day, another officer completed an induction interview with the man. During the interview, the officer asked a number of questions that required the man to respond either yes or no. He responded that he knew why he was in prison, but did not know exactly where he was or any details about his sentence. The man said he had not notified anyone that he was in prison. The man was also recorded as not having problems relating to alcohol or drugs, did not need help with benefits or housing, and did not need to see anyone from probation.
19. In early November, staff noted in the man's wing history sheet (a record of an individual's actions, behaviour and demeanour) that he pressed his cell bell a lot and was quite demanding of staff. He repeatedly asked for Listeners, and each time staff ensured a Listener was made available.

Houseblock 4

20. The following day, the man was transferred to houseblock 4. When prisoners first arrive on the wing from the first night centre, they are held in a holding cell with other prisoners moving to the wing the same day whilst staff arrange the accommodation. Whilst in the holding cell, the man constantly banged on the door and shouted. Senior Officer 1 on the houseblock asked to speak to the man. During interview with my investigators, the Senior Officer said:

“Obviously I was going to say that [his behaviour] was not what was expected on houseblock 4, to manage the prisoner, if you like. But when he came through and I started to explain to him that this wasn't an acceptable way to behave on the houseblock, he became very emotional, tearful and then started to explain to me that he had lost his entire family in the tsunami, which rocked me back on my heels a bit and made me feel a bit guilty about what had happened so then I listened to him more after that.”
21. The conversation lasted about 15 minutes. The Senior Officer said that the man spoke reasonably good English, and understood what was being said to him. However, he really wanted to speak to someone in his own language. The Senior Officer asked the man if he had any thoughts of self harm, which he adamantly denied. By the end of the conversation, the man appeared calmer and more settled. The Senior Officer spoke to another prisoner, whom he believed spoke the same language as the man who died. He asked him to go and talk with him. The prisoner spoke to the man for about five

minutes and reported that he thought the man's English was quite good.

22. The man shared a cell with another prisoner from early November for about a week. The prisoner described the man's behaviour as very changeable. He reported that the man often cried, and talked about missing his children. He said the man was anxious about why he was in prison, about what sentence he might get, and he constantly asked for tobacco. He was not used to prison life and would ask the same question repeatedly. Sometimes, the man would wake the prisoner in the night to ask the same questions. He often started shouting and banging in his cell. Some prisoners found him annoying as he kept them awake.
23. The prisoner reported that he had helped the man write to his solicitor, but that he could make himself understood and seemed to understand most things that were said to him. The man ate well and sometimes he would eat the prisoner's left-over food too. The prisoner said that the man seemed content when he had a cigarette, but when he did not have any tobacco he would bang on the door and pipes.
24. Staff continued to report that the man was demanding of their time and repeatedly pressed his cell bell, asking for Listeners. Again, Listeners were provided when requested.
25. In early November, Senior Officer 1 acknowledged these points but reminded wing officers that Listeners must be called for when requested. The Senior Officer sent a referral to the Mental Health In Reach Team, suggesting that the man might need some bereavement counselling. He was concerned that the man had suffered a number of bereavements, compounded by the fact that he now had no contact with his wife and child. This left the man somewhat isolated and the Senior Officer was concerned that he was "in a bit of a crisis."
26. Staff noted in the man's wing history sheet that he continued to ask for Listeners, and sometimes asked for someone who could speak his language although they felt he could understand English quite well. Staff noticed that occasionally on association the man would sing and dance in return for cigarettes. The prisoner who shared a cell with the man also said that sometimes the man would sing and dance. This would be in his "native language", and then some prisoners would give him tobacco in return. The man would seem very happy at this, sometimes overly happy. The man usually went out on association and appeared to enjoy going outside. One officer reported that she had heard some prisoners teaching the man English swear words. They would then send him off to other prisoners to swear at them, without the man necessarily knowing what it meant. Officer 2 said the behaviour of prisoners towards the man was more: "mucking around ... They weren't being nasty at that stage; I think they were just doing it for a laugh."

27. In early to mid November, the man again asked for a Listener. The Listener complained to staff saying that the man was asking for tobacco and abusing the scheme. Later that day, he went outside to get some exercise. Whilst on exercise it came to an officer's attention that the man had been asking other prisoners of ways to commit self harm. The officer reported this to Senior Officer 2. Senior Officer 2 could not recall who the officer was, but said he told them if they had any concerns they should open an ACCT document. He also said he would speak to the man at dinner time. When the man came down for his dinner, Senior Officer 2 asked him about what had happened. The man said he had been upset about his overall situation since coming into prison and the loss of his family, but denied asking other prisoners how he could self harm and said he had no interest in it. The man who died said he would like to go to education to keep himself busy. The Senior Officer 2 therefore advised him to make an application.
28. The prisoner who shared a cell with the man told my investigators that the following day (in mid November) he had seen a noose that the man had apparently made and asked him about it. The man hid the noose and denied having made one.
29. Shortly after, Officer 3 conducted a cell fabric check in their cell. (This a mandatory security check, where staff examine the cell walls, locks, bars and general fabric of the cell to check they are in good working order.) Whilst Officer 3 was in the cell, he told my investigators that the prisoner who shared a cell with the man who died had told him about the noose under the man's pillow. Officer 3 checked and found the noose inside the pillowcase. He asked the man about it. The man replied, "I'm not going to do anything, I am sorry." Officer 3 appropriately decided to begin the self-harm monitoring procedures by opening an ACCT document.
30. It is the residential manager's role to complete an initial action plan for the ACCT by considering what steps should be taken to ensure a prisoner's safety for the first 24 hours. The prisoner must then have an assessment to identify trigger factors and formulate an appropriate individualised plan of care and support. However, as this was a Saturday, and knowing it might be difficult to find a trained assessor on a Sunday, Senior Officer 2 contacted the safer custody officer and a trained ACCT assessor, and they interviewed the man together.
31. During the assessment, the man categorically denied making the noose but had no explanation as to why it was found in his pillow case. He also denied any thoughts of self harm or suicide. He said that he was not being bullied or intimidated and that he got on with everyone. He also said that he wanted to remain in his current cell as he liked his cellmate and found him to be supportive. The safer Custody Officer said the man appeared buoyant and exuberant during

the assessment, sometimes overly so. Due to the uncertainty of how the noose came to be found in his cell, they decided the ACCT document should remain open and should be further reviewed in two days. They considered the man to be a low risk. The required frequency of observations was written on the front cover of the ACCT. It was recorded as “frequent and irregular intervals”, to be documented at least once in the morning and once in the afternoon.

32. That afternoon, the man was supervised regularly by staff. They noted he was sleeping during the lunchtime period and then asked for a Listener, which was provided. He said he was “ok”. At 5pm, Officer 3 made a note in the ACCT that the man had spoken to him about his children and was upset and crying. Officer 3 told my investigators, “he was always on about all of his family, they had died in the tsunami and he got upset a couple of times: ‘My children, my children’, you know.” The night orderly officer noted that the man was checked regularly through the night. Nothing else significant was recorded.
33. On a morning in mid November, the man did not take his breakfast but did go outside for some fresh air. Later in the morning, the prisoner with whom the man shared a cell, asked to move cells. The prisoner said he could not cope with being woken up constantly by the man asking him questions. Officer 2 said that there was nowhere to move him, but if a space became available during the following days she would arrange a move.
34. The same day, the man asked for a Listener twice. He changed his mind the first time, but later repeated his request and this was facilitated.
35. The following morning, the man again saw a Listener. Staff reported that he was particularly demanding of their time, and kept pressing his cell bell requiring their attention for “trivial reasons”.
36. At 2.45pm on a day in mid November, a review of the ACCT was held. The Senior Officer 2 attended, along with the safer custody officer, a mental health nurse, a psychologist and the man himself. The man still denied making the noose, and the review team concluded that it was reasonable to think that it might have been planted under his pillow by another prisoner with a view to getting the man moved to another wing. They commented in the review that the man was a demanding individual, whose behaviour and actions were up and down. Other prisoners did not want to share with him. They agreed they would try to get a place for him in education which would keep him occupied. They collectively agreed to close the ACCT document. The safer custody officer then made an entry in the wing observation book that the ACCT had been closed, but staff should still monitor the man’s mood and note it in his history sheet as this would assist with his mental health assessment. The mental health nurse also made a detailed note of this meeting in the man’s medical record, and

arranged an appointment for a mental health assessment for 17 November.

37. The prisoner who shared with the man who died moved cells in mid November, the same day the ACCT was closed. The prisoner told my investigators that, at some point during the time they were sharing a cell, he had woken up and seen that the man had tied his shoe laces around his neck and around the bed. He said he took the shoe laces off the man and informed staff, but they did not seem to take much notice. The prisoner said he was not sure they actually heard. The prisoner was not certain when this actually happened, but he thought it was after finding the noose on in mid November. The prisoner thought staff might have thought he was “kidding about the laces”. Certainly, my investigators asked a number of staff if they were aware of the man making a noose from shoe laces, and no staff had any recollection of this.
38. The prisoner’s general opinion of the man was that he was probably mentally ill and found it difficult to cope. He felt that the man needed more to occupy his time. He recalled the man saying he felt that he would be better off dead. The prisoner said he told him to see the prison doctor, but felt the man might have been scared of seeing the doctor.
39. After the prisoner was moved, another prisoner, Mr M, moved into the cell. However, the Officer 2 said that the man also woke Mr M during the night which had scared him. The man was shouting and banging on the pipes that ran along the back wall of the cell. This led to other prisoners on the wing getting upset and annoyed with the man. This is noted in his wing history sheets. Consequently, the man who died was placed in a single cell in Mid November. The prisoner who had shared a cell previously with the man, was keen to tell my investigators that, even though some prisoners may have found the man annoying, there were also a lot of prisoners who were supportive and friendly towards him.
40. Over two consecutive days in mid November, there are several entries in the wing observation book and the man’s history sheet recording that he was making a lot of noise banging on his pipes, and constantly pressing his cell bell. The Officer 2 issued a warning for the misuse of his cell bell on 16 November. By the morning of the second consecutive day in mid November, staff were aware that prisoners had been shouting from their windows at the man, saying they were going to kill him when his door was opened. Later in the morning, staff also heard that the man was being called a “nonce”, a prison slang term for a sex offender. Staff could not identify which prisoners were making the threats as they were behind their doors at the time. However, they were sufficiently concerned for the man’s safety that they immediately reported it to the Senior Officer 1. Senior Officer 1 spoke with the man. The man told him that he was aware people were

calling him a rapist and threatening to kill him, but he did not know who specifically was shouting the abuse. Senior Officer 1 felt the man's safety on the wing had been compromised, and referred the man to the duty governor in order to move him to the vulnerable prisoner unit on houseblock 3 under rule 45 for his own protection.

41. The duty governor, remembered speaking with the man for about 10 to 15 minutes. The Duty Governor felt that the man did not really understand prison life, and was naive to how his actions could be perceived by other prisoners and the implications of his behaviour. After due consideration, the Duty Governor agreed it would be safer for the man to be moved to the vulnerable prisoner wing. He was not sure that the man really grasped the reasons behind the move.
42. The Officer 2 helped the man pack up his belongings and escorted him to houseblock 3. Officer 2 also recalls an officer from legal aid coming to see the man. The legal aid officer said that the Immigration Service were coming to see him that Friday (18 November). Officer 2 remembers that the man understood all this and was concerned that he would be sent back to Asia.

Houseblock 3

43. The man was moved to houseblock 3 which houses the vulnerable prisoner unit. Officer 4, the Centre Officer was the on duty on houseblock 3 that day. (The duties of centre officer are to keep the roll correct and to be in charge of all movements on and off the wing. This includes locating a new prisoner when they move onto the wing.) Officer 4 explained that, when deciding where a prisoner should be located, he would look at the wing history sheets. This would indicate whether the prisoner had any vulnerabilities - such as being on an ACCT, which would normally mean they would go into a double cell.
44. Officer 4 recalled being told by staff that the man was demanding on other prisoners who would get fed up with him quickly. This left the man particularly vulnerable. Officer 4 also saw that the ACCT had been closed, and the very fact it was closed indicated he was no longer deemed to be at active risk of self harming. Officer 4 also remembered when the man had been on the first night centre that his cell mate then had got quite fed up with him. All this considered, Officer 4 decided to locate him in a single cell. The man was therefore allocated cell B2 03.
45. The man's cell was in between two other single cells. In one was prisoner A and in the other was prisoner B. Prisoner B told my investigators about the time the man was on houseblock 3 in mid November. Prisoner B said he spoke to him at times through the pipe in between the cells. He also said he often gave him tobacco. The man talked about his wife going off with another man, and that he had a child. He also told him that he used to work in a factory. The man

seemed to find prison life quite difficult, but did not indicate that he might want to harm himself. Prisoner B advised the man to try and occupy his time and to be strong.

46. The man told prisoner B that he would contact his brother and ask him to send him in some money. Prisoner B said he did not mind helping him with tobacco, as there had been times when he had found life hard and other prisoners had helped him. As the man did not go to education or have a prison job, he would only receive £2.50 a week and £1 of that would be taken for his television.
47. Prisoner B said the man had been quite open with him, and tapped on the pipe when he wanted a chat, some tobacco, or a lighter. However, he was different on association when he seemed more timid and wary. Prisoner B also recalled that at night some prisoners from houseblock 4 shouted at him. Some were asking if he was okay and others shouted insults. The man would apparently shout back and did not seem intimidated by this.
48. Prisoner B said that the man often asked him how long he thought he would get on his sentence. Some other prisoners had told him that he might be facing between 10 and 20 years, but Prisoner B had felt it was more likely to be about 18 months. The man asked Prisoner B if he could trust him. Prisoner B reassured him. He explained that he would only serve half of the time, and when he returned to court in January it might be decided he had already served sufficient. This was something that had really concerned the man. The man had said he was expecting the Immigration Service to see him and he was nervous about this.
49. My investigators also spoke with staff who had been on duty over the few days the man was on houseblock 3. Officer 5 said that, although the man was only on the houseblock a short time, you could not help but know him. The man pressed his cell bell all the time, and was constantly asking when Immigration were coming. On one shift, possibly mid to late November, the man thought that Immigration were coming at 11am the following day and kept asking about it. Other staff also mentioned that the man asked them about Immigration. The man asked repeatedly how long he was going to get as a sentence. He apparently believed it might be over ten years. Officer 5 said that, during any given shift, you could spend as much time with the man as you did with all the other prisoners on the wing put together.
50. The man was obviously concerned about Immigration and his potential sentence, but staff did not consider that he was upset or depressed. Officer 5 remembered coming in one morning and, hearing the man kicking his door, one of the other officers said he had been doing that all night.

51. Officer 5 said that when the man was on association, he felt he had to keep looking out for him. The man was always asking other prisoners for cigarettes, and Officer 5 was worried that the other prisoners were beginning to pick on him. Officer 5 felt that he communicated quite well with the man. He said he could understand the man and the man seemed to understand English quite well. However, Officer 5 was not convinced that the man always understood the full meaning of what was being said, and he certainly did not appear able to grasp what prison was all about, or perhaps even why he was in prison.
52. On in mid to late November, the man declined his appointment with the mental health nurse for a mental health assessment. The mental health nurse informed the Senior Officer and decided she would follow this up with a letter to the man.
53. That evening at 11.10pm, the man pressed his cell bell and asked to see a Listener. Officer 6 who was the night patrol that evening, noted that he seemed "a bit distressed." Officer 6 therefore took the Samaritans phone to the man who spoke on it for about half an hour. When Officer 6 returned, the man appeared more settled.
54. The man made a number of telephone calls during his time at Holme House. In the last few days these were to his niece, and he spoke in his first language. My investigators had the last four telephone calls translated and transcribed into English. He made two calls in mid November at 6.09pm and 6.43pm. In the first call, the man was concerned that he would be kept in prison for years. His niece reassured him that she felt it would be some days, but not years. The man talked about his love for his child and his wife. The conversation then continued:

The man : If anything happened to me they will call you, alright.

Niece: You always tell stories like this.

The man: What?

Niece: You always tell stories like this.

The man: I can't live like this. I can't live alone in the prison leaving my child and family.

55. In the second call at a later date at 6.43pm, the man's thoughts were again dominated by how long he would spend in prison and once more his niece tried to reassure him.
56. The following day, between 9.31am and 12.49pm, the man pressed his cell bell seven times. Although staff could not remember specifically the reason behind the calls, it was thought it was the same questions regarding his sentence and Immigration. In the morning, staff perform the 'kit change', where prisoners put their clothes and bedding out and they are changed for clean ones. This is followed by exercise. No-one my investigators spoke to recalled whether the man had gone outside for exercise that day.

57. In the afternoon, Officer 7 remembers that the man came out for association. He approached Officer 7 to ask how much money he had in his 'spends' to buy canteen (items from the prison shop). Officer 7 said it was approximately £2.32 or £2.52, but cannot now remember how the man appeared in himself.
58. During association, the man made two further phone calls to his niece. The first was at 2.31pm. In this call, it seemed as if the man was losing hope as he said "how can I stay here, you can't do anything?" Again his niece reassured him, that she was sure he would serve days not years. The man also asked if she knew if his daughter was being cared for, and his niece replied that she felt she would be being treated well.
59. Twenty minutes later, the man phoned his niece again. He asked her to buy something for his daughter if she saw her and if she asked for anything. He said that his daughter had no-one. The man cried during the phone call, and said he felt that he had fallen into a net without knowing. He asked how his daughter had been in the last two months, and his niece replied that she did not know. The man then repeated his request for her to buy his daughter anything she wanted, and said he would call later.
60. That evening in his cell, he spoke to Prisoner B through the pipes. Prisoner B recalls the man asking him for a cigarette, and Prisoner B passed one through. About half an hour later he asked for another, but Prisoner B only had two more to last him so he said he could not oblige. Prisoner B heard the man then bang on his wall to ask the prisoner located in the cell on the other side (Prisoner A). Prisoner A confirmed this in interview, and said he passed the man who died a cigarette through the pipes at about 11.30pm. Prisoner A fell asleep soon after. Neither Prisoner A nor Prisoner B heard anything else from the man's cell that night.

20 November

61. In mid to late November, Officer 6 was conducting the early morning roll check on houseblock 3, B landing. (This is a mandatory check, where the officer has to physically check that all prisoners are in their cells.) Staff must see the prisoner by looking through the observation hatch in the cell door. When Officer 6 reached the man's cell, he could only see his bottom half. Officer 6 banged on the door and called to the man, but received no response. Officer 6 therefore returned to the office, and phoned the night orderly room and informed the assistant night orderly officer, Officer 8, that he could not get a response from the man's cell. Officer 8 immediately phoned the night orderly officer, Senior Officer 3, who was at that time in the communications room. As night orderly officer, Senior Officer 3 was the most senior person in the prison, and the only one to carry keys.

(Each officer carries a cell key in a sealed pouch to be used in emergencies.) Senior Officer 3 ran to houseblock 3, collecting Officer 8 from the orderly office on the way. Senior Officer 3 said they were at the cell within minutes.

62. At approximately 5.50am, Senior Officer 3 opened the man's cell door. They found the man had made a ligature from a piece of torn bed sheet and secured it to the waste pipes under his sink. Officer 6 used his "fish knife" (anti ligature knife) to cut the ligature and lower the man to the floor. Whilst this was happening, Senior Officer 3 used his radio to inform the communications room and others that there was a "code blue" (this emergency radio code signifies a prisoner is not breathing). The officer in the communications room called an ambulance. Officer 8 then went to the gate to ensure that the ambulance and paramedics were afforded ready access.
63. At approximately 5.52am, Nurse 1 and Officer 9 arrived at the man's cell. Nurse 1 said that when she touched the man he was stiff and cold. She attached the defibrillator machine, which showed there was no heart activity. Nurse 1 and Officer 9 then commenced cardio pulmonary resuscitation (CPR). Nurse 1 performed chest compressions whilst Officer 9 performed artificial respiration using an ambu bag (an air bag used to blow air into the airway). They continued with the CPR until the paramedics arrived. At no time did the automatic external defibrillator indicate there was any heart activity requiring a shock.
64. The paramedics arrived at Holme House just before 6am and were at the man's cell just minutes later. They asked staff to stop CPR. They noted that there were no vital signs and that rigor mortis was present. Although the paramedics were able to give permission to stop CPR, a doctor was needed to officially pronounce death. A Doctor arrived and pronounced the man dead at 6.35am.

Action following the man's death

65. The death in custody contingency plan was instigated. The duty governor attended Holme House. All staff involved in trying to save the man made statements and attended a hot debrief, and were subsequently offered care and support.
66. The prisoners located in the cells either side of the man were taken to a room and told the news of his death. They too were offered support. A notice was put on the other wings. The former cell mate, who had shared with the man previously, said he learned of the man's death via one of these notices and that he had not taken the news well.
67. The man had recorded his next of kin as his wife. The Duty Governor went to the given address in order to break the news in person, but found the house was boarded up and she had moved. Staff then

searched the man's records in an attempt to locate another family member. They located the man's brother in London and, due to the distance involved and the need for timeliness, broke the news by telephone.

68. Later, at the invitation of the Governor, members of the man's family were able to visit Holme House and his cell.

ISSUES

Management and understanding of challenging behaviour

69. During his time at Holme House, the man requested Listeners on a daily basis. There is evidence that on at least one occasion this was to ask for tobacco, and was manifestly not an appropriate use of the Listener scheme.
70. There are numerous examples where the man made a great deal of noise, usually by banging on pipes in the cells he was in. Undoubtedly, staff had to spend a great deal of time and effort responding to the man. I can understand that at times this may have been frustrating. In the main, staff responded appropriately to his needs and demands. However, some of the entries in the wing log book and the man's history sheet show a lack of compassion and sensitivity.
71. Whilst in Leeds, the governor authorising the man's move to the vulnerable prisoner wing, mentioned that he was not 'wise' to prison life. Indeed, before his remand on 6 October, the man had never been in prison before. It is also possible that what he had heard about prisons in Asia may have influenced his perception of prisons in Britain and left him wary. Some staff raised similar concerns in Holme House. Furthermore, his naivety was demonstrated in that he seemed unable to understand the impact of his behaviour on other prisoners and their possible reaction.
72. The man continuously asked the same questions of staff and other prisoners. A major concern was how long he might serve in prison. It is thought that some prisoners grew frustrated with this question and flippantly replied that he would be there for years. The man certainly felt he might be in prison for a considerable length of time, despite reassurance from his family and Prisoner B. There is also evidence that the man was not sure whom he could trust.
73. Officer 2 reported that the man was warned to expect a visit from Immigration. In fact, immigration officers were not due to see the man, and it is thought that the officer who told the man had mistaken him for another prisoner. This was another big worry for the man. He told Prisoner B that he was concerned he would be sent home. The man's brother told my investigators that a number of his family were killed in a bombing in Asia, and he did not feel safe there.
74. There are a number of possible explanations for the man's behaviour. First, it is entirely possible that the man was mentally unwell. There are certainly examples of erratic and distressed behaviour, coupled with a lack of understanding. The man had lost family members, and had now lost contact with his wife and daughter to whom he was obviously devoted. This left him particularly isolated and perhaps

depressed. The man's brother told my investigators that their experiences in Asia left them with mental scars, and several family members had subsequently suffered with mental ill health.

75. Conversely, the man was able to behave as if nothing was wrong at all. Whenever challenged about his feelings, he was emphatic in his denials of self harm or of not being able to cope well.
76. Secondly, the man's ability to communicate effectively in English is open to debate. The man's brother reported that his English was not good. Whilst he might have been able to communicate on a basic level, he did not have a depth of knowledge of the English language. On reception at Holme House, the man's English was recorded as poor, yet it does not appear that he was provided any information in his first language. Some staff noted that his English was not good, whilst others felt he understood a large amount and was able to express himself. Certainly, it would appear that he was able to communicate well in his ACCT review. However, it is less clear whether he would have the language to express how he really felt. There are several occasions where he asked to speak to someone in his own language. Senior Officer 2 noted in the man's care map in his ACCT on 12 November that the man was becoming more isolated due to poor English.
77. The fact that he asked the same questions repeatedly of both staff and prisoners, even waking his cellmates, could demonstrate that the man was deeply worried, or did not fully understand the responses he was receiving. It may be that he did not fully comprehend the purpose of the Listeners scheme. Staff did not feel confident that he fully understood what rule 45 was, and why he was being moved.
78. When asked, staff said that if they needed to communicate with someone who did not understand English, they could use Language Line (a telephone system involving a three way conversation with the prisoner and an interpreter). This was not used for the man. Senior Officer 1 made some attempts to locate a prisoner who could speak the man's language, but it is not clear if the prisoner he found was actually the man's language or just spoke to the man in English.
79. When the man arrived and was taken to the first night centre, some effort was made to put him with another Asian prisoner. However, my investigator felt that there was a lack of understanding of the needs of foreign national prisoners, and a lack of empathy to the fact that the man had poor English.
80. Her Majesty's Chief Inspector of Prisons (HMCIP) inspected Holme House in April 2005 and found:

“Some contacts were superficial and did not take account of individual needs ... prisoner relationships throughout the establishment appeared

to be soundly based and reasonably business-like, although staff were not particularly warm to prisoners. We saw no inappropriate behaviour ... However, we were concerned by examples where staff seemed to marginalise some minority groups, such as foreign nationals and older prisoners. Although such prisoners needed staff support to exercise basic opportunities, staff appeared to be responding to requests rather than actively checking that their needs were met.”

81. My investigators found this to be the case with the man. Staff answered his cell bell, helped him with his canteen sheet etc, but actions tended to be responsive.

Foreign nationals

82. At the time of the investigation, Holme House did not have a formal policy for foreign nationals, although they did have one in draft. The race relations liaison officer was expected to absorb the work relating to foreign nationals into his normal working week. The race relations liaison officer, a prison Senior Officer, was allocated eight hours per week to perform his race relations and foreign national duties, but frequently found he was allocated to other work and it was difficult to fit all the required tasks in. Although he felt supported by management, he found that eight hours was not enough to complete his work.
83. The race relations liaison officer said that the induction booklet is in draft in a number of different languages. There is an induction booklet available and explanations of certain prison procedures, such as adjudications and how to make complaints, available in the man’s language. It is not clear whether the man received these.
84. The race relations liaison officer’s knowledge was impressive, but self taught through reading about different religions and ethnic groups. The race relation liaison officer had built up good links with Stockton International Family Centre, and had made enquiries attempting to find a befriender who spoke the man’s language (although this was not specifically for the man). The race relations liaison officer had also made contact with other external agencies and had forged links with Stockton Council resulting in good partnership working. This included being able to access the multi-lingual library services to obtain books and newspapers for prisoners in different languages.
85. At the time of investigation, there were 29 foreign nationals and 67 prisoners from 1 and minority ethnic groups at Holme House.
86. The race relations liaison officer held monthly race relations meetings and these had a stable and good attendance, including by some outside agencies. They reviewed racist incidents and the race equality impact assessments, and discussed monitoring.

87. Training records demonstrated that 85 per cent of staff were trained in race and diversity awareness, which exceeded the target. However, it was unclear whether this included specific information about resources available at Holme House.
88. My investigators noted that a Senior Officer worked full time as the safer custody officer. Staff were fully aware of all suicide prevention measures and the Safer Custody Officer was readily available as a resource to staff. The Safer Custody Officer had a daily physical presence on the wings, and encouraged and reminded staff of their responsibilities and care towards specific prisoners, both verbally and through writing in the wing observation books.
89. Staff have a duty to be aware of the potential needs of foreign national prisoners, to be sensitive to those needs, and to know how to access appropriate services. If staff do not feel confident, they should contact race relations liaison officer and ask for his advice, or ask for him to undertake an assessment of need.
90. HMCIP report also found that work with foreign national prisoners was: "... an underdeveloped area, which needed immediate attention." Managers were aware of this need. HMCIP concluded that: "The absence of a foreign nationals committee or any self-help group made it more difficult for staff to be aware of, and subsequently meet, the distinctive needs of this group of prisoners."
91. HMCIP found that a booklet on *Information and Advice for Foreign Prisoners* was available in the library in a number of languages. Additional information was available to staff on the intranet, including a foreign national resource pack. There was no evidence that this material was in fact used with prisoners.
92. My investigators judged that staff were not proactive in meeting The man's needs as a foreign national, in particular his language needs. Staff did not seem aware of their responsibilities in this respect, and this is likely to be because there was no existing policy or co-ordinator at a management level.

The Governor should remind staff of the need to pay attention to the individual needs of foreign nationals and the facilities available at Holme House. When a prisoner requests to speak to someone in their own language, this should wherever possible be facilitated.

A foreign national co-ordinator should be appointed and allocated an appropriate number of hours to dedicate to this area of work. The co-ordinator should have a visible presence of the wings to ensure the needs of foreign national prisoners are being considered.

Bullying

93. It is quite clear that the man's behaviour left him vulnerable to abuse from other prisoners. At Leeds, staff had identified that he was subject to serial abuse from others and therefore moved him to the vulnerable prisoner unit for his own protection.
94. Several staff told my investigators that, whilst on houseblock 4 at Holme House, they saw the man 'perform' in return for tobacco. This conjures up some extremely unpalatable images. Staff reported that they had not seen this as bullying as the man seemed quite happy. Officer 2 told my investigators she remembers one of the prisoners who worked on the servery mocking the man, and she told him to stop. Apart from this, there seems no recognition that this constituted unacceptable and bullying behaviour. Staff should have been more alert to the man's vulnerabilities.
95. My investigators examined the anti-bullying policy, which was clear and in line with national policy.
96. The HMCIP report found that there were two anti-bullying liaison officers in each houseblock, but their attendance at violence reduction meetings was irregular. Other houseblock staff were often sent in their place, but had not been briefed to provide any feedback. Consequently, information was often patchy. I concur with the HMCIP recommendation, "Anti-bullying liaison officers should be more active in implementing an effective strategy." Certainly, staff need to be aware of the varying forms that bullying can take.

The Governor should remind all wing staff of the varying forms that bullying can take.

97. It should be noted that, when the man's physical wellbeing was threatened, staff acted promptly and appropriately. The decision to move him for his own protection was correct.

ACCT

98. The man's ACCT was opened on 12 November, following Officer 3's discovery of a noose in his pillow. This too was the appropriate course of action. When the officer found the noose and asked the man about it, his response was "I'm not going to do anything. I'm sorry". Officer 3 recorded his concerns in opening the ACCT, and gave the reasons for opening it as being due to finding the noose and the man's previous comments of "going to try and kill himself". Officer 3 also noted, that, when challenged, the man said he had no problems and no intention of self harm or suicidal thoughts.
99. The ACCT was then passed to the wing manager on duty, in this instance Senior Officer 2. Senior Officer 2 showed good awareness in

contacting the Safer Custody Officer about conducting an assessment the same day, given it was a Saturday. Senior Officer 2 told investigators the ACCT was opened because of the noose, and the comments of others that the man was asking other prisoners how to harm himself. However, it appears that this information was not brought to the attention of the Safer Custody Officer or the other staff involved in the review two days later.

100. The man adamantly rejected any thoughts of self harm, as he had previously done when concerns were raised. He denied making the noose and also denied that he had ever considered self harm or suicide in the previous year. The Safer Custody Officer noted that, during the assessment, the man appeared buoyant and exuberant, at times overly so. They agreed to keep the ACCT open and to review it two days later, as they were unsure as to how the noose came to be where it was found.
101. At interview, Officer 3 told my investigators that the man's initial reaction was to say that he was sorry, and did not deny knowledge of how the noose. This was not recorded elsewhere for staff to consider. The Safer Custody Officer told investigators that the man was emphatic in his denial of making the noose: "we were actually asking him, 'What is this all about?' and he was saying, 'Oh, no it wasn't me, I have not done that, I have not done that.' We were 'Are you sure?' and he was 'Oh no I have never done that, I have never done that'. It wasn't just a case of, well a bit sheepish and you have caught me out, it was very vehemently denying it."
102. The safer custody officer said that the man told them his wife wanted to visit with his children and he was very positive about this. However, there is no evidence that he had any contact with his wife whilst in prison. Indeed, he could not do so due to his alleged offences against her.
103. The case review of the man's ACCT took place in mid November. Those at the review (apart from the man himself) were the Safer Custody Officer, Senior Officer 2, the psychologist and the Registered mental health nurse. This represents a good multi-disciplinary presence and, with the attendance of the two Senior Officers, ensured continuity from the initial assessment.
104. All the staff at the review told my investigators that the man was emphatic that the noose that been planted in his cell and he had nothing to do with it. He said that he had no intention to self harm and did not understand why other people did. He was extremely plausible. The Safer Custody Officer reported that the man had said that he would never kill himself because his children needed him. It was also reported by Senior Officer 2 that prisoners had been seen coming out of his cell shortly before the noose was found, so it was a plausible explanation that it had been planted. The psychologist and Mental

Health Nurse both said they asked a number of searching questions and were left feeling confident that the man did not have any ideas of self harm.

105. The psychologist remembered that the man's mental capability had been questioned, but felt his behaviour was more to do with a lack of cultural understanding and his naivety about prison and prison life. The Mental Health Nurse also said she did not see any evidence of mental illness.
106. The man said that he got on with other prisoners and was not being bullied, although Senior Officer 2 knew he was not well liked on the wing.
107. The review team all agreed the closure of the man's ACCT. The Psychologist commented that, when she heard of his death, she was quite shaken. She felt that the man must have either been very good at covering up how he was feeling or had acted on impulse. She certainly did not have any indication that suicide was on his mind at the time of the ACCT review.
108. It is difficult to know if the man was a proud man, or saw it as shameful to have suicidal ideas. Whatever the case, he was extremely convincing. Four professionals, with a good and varied range of knowledge and experience, all believed that he was not at risk of self harm or suicide, at that time.
109. My investigators examined a sample of other ACCT documentation that had been recently closed. My investigators found the ACCT documents to be of a good standard, with some high-quality initial assessments and good attendance at reviews. However, my investigators were concerned by the prompt closure of some of the forms when there were apparently still some concerns. This was reported to the Governor at the time of the investigation.
110. The policy and procedures in place for managing those at risk of suicide and self harm were of a high standard. The Safer Custody Officer was committed and knowledgeable, and there was a clear "top down" approach to suicide prevention at Holme House. This is demonstrated by the Safer Custody Officer's role being identified as a full time position. Although he has a range of tasks to carry out, it does ensure that he is a visible presence regularly on the wings and continually promotes and checks on the care of those deemed at risk of suicide and self harm. The Safer Custody Officer himself was seen as a valuable source of information and advice by staff.
111. The HMCIP report spoke favourably of the systems in place in regard to suicide prevention.

Accommodation

112. The man's brother raised particular concerns to my investigators about the man being in a single cell at the time of his death. There are several issues that warrant further examination regarding this matter.

113. PSO 2700: Suicide and self harm prevention states:

Shared accommodation:

At-risk prisoners should be routinely allocated to shared accommodation, unless the prisoner represents a risk to others, their behaviour is too disturbing to other prisoners or shared accommodation is not available. Two at-risk prisoners should not share a double cell. If it is not advisable or practical to place a prisoner on an open F2052SH in a shared cell, the reason for the allocation to a single cell should be recorded in the F2052SH, and additional protective measures put in place to compensate for the added risk. (*F2052SH is the old system for monitoring prisoner at risk of suicide or self harm, since replaced in many jails by ACCT.*)

114. The prisoner who shared with the man originally, was moved to another cell in mid November, after complaining that he could not sleep properly as the man kept waking him during the night. Another prisoner, Mr C, shared with the man for one night. However, Officer 2 said that the man also woke him during the night which had made Prisoner C quite scared. The man was also shouting and banging on the pipes in his cell. This led to other prisoners on the wing getting upset. This is recorded in the man's wing history sheets. Consequently, the man was placed in a single cell in mid November. This was a day after the ACCT was closed, and therefore technically outside of the requirements of PSO 2700. However, I have had the sad duty of investigating a number of deaths where a prisoner has apparently taken their own life shortly after being placed in a single cell, and would alert staff to the potential additional vulnerability this may cause. That said, given the man's behaviour in waking cellmates and being noisy and disruptive, I cannot conclude other than that it was appropriate that the man was allocated a single cell.

115. The man moved to houseblock 3 in mid November. Officer 1 decided to allocate the man a single cell based on the information he received from other staff. He was told that the man was demanding on other prisoners, resulting in them getting fed up with him quickly and which could leave him vulnerable. Officer 1 also remembered when the man had been on the first night centre that his cell mate had got fed up with him. I understand the rationale behind this decision and I am not critical of it.

116. That said, staff on houseblock 3 generally did not seem aware that the man's the man's ACCT had been recently closed. Similarly, the note

that The Safer Custody Officer had made in the wing observation book, following the ACCT review regarding monitoring the man's mood and behaviour, was not handed over to staff on houseblock 3.

117. It would be good practice for the officer relocating a prisoner to make a note in the wing observation book if an ACCT has been closed in the previous fortnight, and to draw attention to any specific issues. All staff are required to read the wing observation book when they arrive on duty, and this would alert them to potential vulnerability issues.

The Governor should ensure that there are appropriate systems in place so that relevant information is communicated in a timely manner.

Clinical issues

118. On 9 November, Senior Officer 1 referred the man to the mental health in reach team and mentioned that he might need bereavement counselling. This referral was received by the mental health nurse and she arranged an appointment for 17 November.
119. The mental health nurse also attended the man's ACCT review on 14 November. The Safer Custody Officer spoke to the mental health nurse about some strange behaviour that the man had been exhibiting. The mental health nurse told my investigators that she did not see anything in his demeanour that raised any immediate concerns. She checked the wing history sheets. Whilst she noted the comments about constantly ringing his cell bell and banging on the pipes, she did not feel this constituted anything of particular concern. She asked the Safer Custody Officer to ask staff to write anything that they felt was strange behaviour in the wing sheets, so she would be able to read these before assessing the man's mental health. The Safer Custody Officer did as she asked.
120. The man declined to attend his appointment on 17 November. This was the first time the mental health nurse had known a prisoner refuse an assessment, so discussed any potential follow up with colleagues. It was felt the man had a right to decline the assessment and, given the mental health nurse had spoken with him at some depth during the ACCT review earlier in the week, she was not concerned that he was presenting acute mental health problems.
121. The mental health nurse informed the Safer Custody Officer of the man's decision the following day. She also drafted a follow up letter, identifying the route available to him if he felt he wanted assistance in the future. This letter was given to the typing pool, but was not typed until Monday 21 November (after the man's death).
122. There is some evidence to suggest that the man was nervous of medical intervention. In addition to his declining his mental health assessment, another prisoner said he had advised the man to speak with the doctor but felt he was scared to do so. Furthermore, in his ACCT assessment, Senior Officer 2 reported that he mentioned the option of the man moving to the healthcare centre. the man was adamant he did not want to go. (It is of course a patient's right to refuse assessment and/or treatment when in prison, as in the wider community.)
123. The Clinical Governance Lead for North Tees Primary Care Trust completed a clinical review. The doctor concluded his report prior to the completion of my investigation, and some of the points he raises are answered by my own investigation. However, he does make the point that, although the records were complete, it was not always clear

who had made entries. I therefore endorse the following recommendation:

All clinical staff should be reminded that entries in clinical records should be timed and the name of the member of staff attached as per the NMC guidelines

Crisis management

124. On the morning of 20 November, Officer 6 could only see the man from the waist down on the floor in his cell when conducting an early morning roll check. Officer 6 appropriately tried to get a response by banging on the door and calling out. Officer 6 returned to the office, phoned the night orderly room and told the assistant night orderly officer, Officer 8, that he could not get a response from the man. It is unclear why he did not use his radio to make contact, although it is acceptable procedure to use the phone. Officer 8 then immediately phoned the night orderly officer, Senior Officer 3, who was in the communications room; again it is not clear why he did not use his radio.

All staff should be reminded to use their radios as the quickest avenue to access support from staff in emergencies.

125. Nurse 1 said that, when she touched the man, he was stiff and cold. She attached the defibrillator, which showed there was no heart activity. Nurse 1 and Officer 9 then commenced cardio pulmonary resuscitation. Nurse 1 performed chest compressions whilst Officer 9 performed artificial respiration. They continued with the resuscitation until the paramedics arrived. At no time did the defibrillator machine indicate there was any heart activity. Nurse 1 told my investigators that there were clear signs that the man was dead, but she would always want to attempt resuscitation in any case.

I recommend that Nurse 1 and Officer 9 should be recognised for their efforts in attempting to resuscitate the man.

126. Following a death in custody, there are a number of duties required of the prison. The most critical is to inform the next of kin, whom the man had recorded as his wife. The duty governor acted appropriately by visiting the address the man had given, but found no-one lived at the address any longer. It took sorting through some of the man's records to locate another member of the family (this was the man's brother, who lives in London). By the time this was done, the duty governor decided to contact him by telephone.

127. I understand the balance that needs to be struck in breaking the sad news of a death in custody as quickly, carefully and sensitively as possible. I do not criticise the duty governor's actions. However, best practice would have been to contact the duty governor of the prison closest to the address, and ask them to break the news on Holme House's behalf.

128. Other contingency plans were actioned in accordance with policy. The prisoners located in the cells either side of the man were taken to a room and told the news of his death. They were offered support. A notice was put on the other wings. However, another prisoner said

that when he learned of the man's death via one of these notices he had not taken the news well.

When dealing with a death in custody, the Governor should try to treat previous cellmates as known associates of the deceased and ask staff to break the news in person.

RECOMMENDATIONS AND GOOD PRACTICE

The Prison Service have accepted all recommendations and established an action plan for their implementation.

1. The Governor should remind staff of the need to pay attention to the individual needs of foreign nationals and the facilities available at Holme House. When a prisoner requests to speak to someone in their own language, this should wherever possible be facilitated.
2. A foreign national co-ordinator should be appointed and allocated an appropriate number of hours to dedicate to this area of work. The co-ordinator should have a visible presence of the wings to ensure the needs of foreign national prisoners are being considered.
3. The Governor should remind all wing staff of the varying forms that bullying can take.
4. The Governor should ensure that there are appropriate systems in place so that relevant information is communicated in a timely manner.
5. All clinical staff should be reminded that entries in clinical records should be timed and the name of the member of staff attached as per the NMC guidelines.
6. All staff should be reminded to use their radios as the quickest avenue to access support from staff in emergencies.
7. When dealing with a death in custody, the Governor should try to treat previous cellmates as known associates of the deceased and ask staff to break the news in person.

Good Practice

8. I recommend that Nurse 1 and Officer 9 should be recognised for their efforts in attempting to resuscitate the man.

ANNEXES

1. Documents considered during the investigation
2. Clinical review
3. Rule 45 paperwork from HMP Leeds
4. Suicide/self harm warning form
5. Medical records
6. Prisoner reception checklist
7. Wing history sheet
8. Wing observation book from houseblock 4.
9. Transcript of interview with Senior Officer 1
10. Note of interview with another prisoner
11. Mental health referral from Senior Officer 1
12. Transcript of interview with Officer 2
13. Transcript of interview with Senior Officer 2
14. Transcript of interview with Officer 3
15. Assessment, Care in Custody and Teamwork (ACCT) documentation
16. Transcript of interview with Safer custody officer
17. Note of interview with the mental health nurse
18. Note of interview with A psychologist
19. Rule 45 paperwork from HMP Holme House
20. Note of interview with the duty governor
21. Note of interview with Officer 4
22. Note of interview with prisoner B
23. Note of interview with prisoner A
24. Note of interview with Officer 5
25. Wing observation book from houseblock 4
26. Transcript of telephone calls made by the man on 18 November 2005
27. Note of interview with Officer 7
28. Transcript of telephone calls made by the man on 19 November 2005
29. Incident reports from:
 - i. Officer 6
 - ii. Officer 8
 - iii. Officer 9
 - iv. Senior Officer 3
 - v. Nurse 1
30. Transcript of interview with Senior Officer 3
31. Transcript of interview with Nurse 1