Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Betteridge, a prisoner at HMP Durham, on 26 May 2015

A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr John Betteridge was found hanged in his cell at HMP Durham on 26 May. He was 43 years old. I offer my condolences to Mr Betteridge's family and friends.

When Mr Betteridge arrived at Durham, he said he had been taking medication for anxiety and depression. However, he did not receive any medication during the short time he was at the prison, because he arrived on the Friday of a Bank Holiday weekend. This meant that healthcare staff at the prison were not able to confirm his prescriptions with his GP until the next Tuesday. Mr Betteridge cut himself and told officers that he found it difficult to cope without his medication.

Although staff began Prison Service suicide and self-harm prevention procedures, I am concerned that they ended these very shortly afterwards, before Mr Betteridge's problems about his medication had been resolved and so soon after he had harmed himself. Two days later, early on Tuesday morning, officers found Mr Betteridge had hanged himself during the night. There was some confusion about the emergency response procedures, which the prison will need to address, but this did not affect the outcome for Mr Betteridge, who was evidently dead at the time he was found.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **January 2016**

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Summary

Events

1. Mr John Betteridge was remanded to HMP Durham on Friday 22 May 2015, facing charges of theft. At an initial health screen, a nurse recorded that Mr Betteridge had a history of drug use. He said he had been taking medication for depression and anxiety but did not have any medication with him. He said that he had self-harmed a long time previously, but had no current thoughts of suicide or self-harm. A urine test indicated that Mr Betteridge had used opiates, but he showed no signs of withdrawal. A prison GP told him that he would not be able to receive his medication until his community GP had confirmed his prescription. As this was a Bank Holiday weekend, this would not be possible until the following Tuesday.

2. Mr Betteridge had a shared cell on F Wing, the wing for new arrivals. On the evening of Saturday 23 May, he told night staff that he would harm himself if he did not receive some methadone (used to treat opiate withdrawal). The duty nurse saw him around 8.30pm and he said he was upset about not having methadone. She noted no signs of opiate withdrawal and said he would need to see the GP to review his medication. She gave him paracetamol for a headache. The staff did not assess him as at risk of suicide or self-harm at the time. Shortly after midnight, Mr Betteridge's cellmate alerted staff that Mr Betteridge had made cuts to his chest and stomach. A nurse dressed his wounds and an officer began suicide and self-harm prevention measures (known as ACCT). The night manager asked staff to check Mr Betteridge at least once an hour.

3. At 4.00am on 24 May, his cellmate called officers and told them that Mr Betteridge had made a ligature from a strip of torn bed sheets. The officers took the ligature, the remaining torn bed sheets and his belt from him. No one reviewed the level of observations and staff continued to check him once an hour.

4. Later that morning, an officer assessed Mr Betteridge as part of ACCT procedures. Mr Betteridge said that he had felt bad during the night, but staff had now given him information about detoxification and the help he could get. He said he now had no thoughts of harming himself. A manager held a case review with no member of healthcare staff present and decided to end ACCT monitoring. Mr Betteridge's cellmate moved later that day, leaving Mr Betteridge alone in the cell.

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5. At 4.55am on Tuesday 26 May, a member of staff found that Mr Betteridge had hanged himself from the light fitting, using his belt - which had been returned to him - as a ligature. He radioed for help but did not use a standard medical emergency code. Other staff arrived quickly but did not attempt to resuscitate Mr Betteridge, as it was evident that he had died. The night manager updated the control room and an ambulance was called at 5.04am. In the meantime, nurses had arrived at the cell and began cardiopulmonary resuscitation, although there were clear signs of death. Paramedics arrived at 5.40am and confirmed that Mr Betteridge had died.

Findings

6. An officer opened an ACCT after Mr Betteridge harmed himself on 24 May. Later that morning, officers removed ligatures from his cell but did not increase the level of observations to reflect the increased risk this represented. Although there is a mandatory requirement that case reviews should be multidisciplinary and that a member of healthcare staff should attend first ACCT case reviews, a supervising officer, with another officer attending, ended the ACCT monitoring, less than nine hours after the ACCT was opened. Mr Betteridge's main issue, his medication, had still not been resolved and he had been found with ligatures shortly before. We consider that the ACCT was closed prematurely and Mr Betteridge did not receive appropriate support.

7. The member of staff who found that Mr Betteridge had hanged himself did not use the appropriate emergency medical code, which meant the control room did not call an ambulance immediately. While this did not affect the outcome for Mr Betteridge, in other emergencies such a delay could be critical. We have made several previous recommendations to Durham about emergency procedures. We are satisfied that officers made an appropriate decision not to try to resuscitate Mr Betteridge. Although nurses attempted resuscitation, this was unnecessary as there were evident signs of rigor mortis, which should have indicated that any resuscitation attempt would be futile.

Recommendations

- The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidance, including:

    - A multi-disciplinary approach for all case reviews.
    - Healthcare staff attending all first case reviews.

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- Reviewing levels of observations whenever an event occurs which indicates an increase in risk.
- ACCT plans are not closed shortly after incidents of self-harm, unless there is clear evidence that the prisoner is no longer at risk and all issues identified at the assessment interview have been resolved.
- All staff in direct contact with prisoners have ACCT training.

- The Governor should ensure that all staff are aware of and use the appropriate emergency response code in a life-threatening situation and that the control room calls an ambulance immediately.

- The Head of Healthcare should ensure that healthcare staff are given clear guidance and training, in line with established professional guidelines, about the circumstances in which resuscitation is inappropriate.

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The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Durham informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

9. NHS England commissioned a clinical reviewer to review Mr Betteridge's clinical care at the prison.

10. The investigator visited Durham on 28 May and obtained copies of relevant extracts from Mr Betteridge's prison and medical records. He interviewed 17 members of staff and one prisoner at Durham in July and August. The clinical reviewer joined him for interviews with healthcare staff.

11. We informed HM Coroner for Durham of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

12. One of the Ombudsman's family liaison officers contacted Mr Betteridge's mother and his partner to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They gave some background information about Mr Betteridge's circumstances. They had the following points, which we have addressed in the report:

    - Did Mr Betteridge have access to medication and healthcare staff?
    - What healthcare assessments did Mr Betteridge have?
    - Were prison staff aware of Mr Betteridge's recent self-harm and what safeguards had they put in place?
    - Was Mr Betteridge on any form of monitoring?

13. Mr Betteridge's family received a copy of the initial report. The solicitor representing the family wrote to us pointing out some factual inaccuracies. The report has been amended accordingly. They also raised a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

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Background Information

HMP Durham

14. HMP Durham is a local prison serving the courts of Durham, Tyneside, and Cumbria, which holds approximately 1,000 men. G4S provides primary healthcare services and Tees, Esk, and Wear Valley NHS Trust provides mental health services.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Durham was in December 2013. Inspectors reported that they were not confident that the risks and vulnerabilities of new arrivals were properly identified. ACCT suicide and self-harm prevention procedures were assessed as poor and case reviews were often not multidisciplinary. Many prisoners said that they felt unsupported by staff. Inspectors noted that some psychoactive medication had been stopped at reception only to be re-prescribed later and recommended that established patterns of prescription were not interrupted without an individual risk assessment. They found that some healthcare providers had differing views about prescribing practice. Inspectors considered that the quality of clinical treatment for substance misusers had improved since the last inspection.

Independent Monitoring Board

16. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to October 2014, the IMB reported that prisoners had a full medical assessment when they arrived. Board members were impressed by the prisoners who delivered induction sessions.

Previous deaths at HMP Durham

17. Mr Betteridge's death was the third self-inflicted death at Durham since August 2014. In recent investigations, we have made recommendations about identifying the risk of suicide and self-harm and the appropriate use of emergency medical codes.

Assessment, Care in Custody and Teamwork

18. ACCT is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT is to try to determine

the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be at irregular intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Staff should hold regular multidisciplinary reviews and should not close the ACCT plan until all the actions of the caremap are completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

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Key Events

19. On Friday 22 May 2015, Mr John Betteridge was remanded to prison charged with theft. He arrived at HMP Durham late in the afternoon. He had previously been at Durham ten years earlier. His escort record, which accompanied him from court, noted that Mr Betteridge had cut his wrists four years earlier but he had no current thoughts of suicide or self-harm.

20. At an initial health screen, Mr Betteridge told a mental health nurse that he smoked between 20 and 40 cigarettes each day and had a history of substance misuse, including heroin. He gave a urine test, which was positive for opiates. The test was negative for methadone. (Indicating he had not been prescribed an opiate substitute in the community.)

21. The nurse recorded that Mr Betteridge had a history of depression and said he had had been prescribed sertraline, an anti-depressant, for the previous eight months. Mr Betteridge told the nurse that he had also been prescribed pregabalin and propranolol, for anxiety. Mr Betteridge said he did not have any thoughts of suicide or self-harm. The nurse did not assess Mr Betteridge as at risk of suicide and self-harm, but referred him to the duty GP, because of his history of substance misuse and depression. He also referred him to the mental health team.

22. Mr Betteridge was allocated a shared cell on F Wing, the prison's first night centre and detoxification wing. An officer interviewed Mr Betteridge as part of the prison's first night procedures to identify any risks, using information from his escort record and taking into account the charges he was facing. Mr Betteridge told him that he had previously self-harmed, but he could not remember when and said that he had no current thoughts of suicide and self-harm. The officer said that the only thing Mr Betteridge appeared worried about was getting his medication. He did not consider he was at risk of suicide or self-harm.

23. Around 4.30pm, Mr Betteridge phoned his partner to let her know he was in Durham prison and apologised for his situation. He said that he had not been given any medication to help with drug withdrawal symptoms (which he called a "rattle pack").

24. A doctor assessed Mr Betteridge at around 8.00pm. Mr Betteridge told him that he had been prescribed pregabalin after having a nervous breakdown and had used heroin in the previous three days, although not each day. The doctor recorded that Mr Betteridge looked fine and he did not note any signs of anxiety.

The doctor told the investigator that he did not consider that Mr Betteridge was depressed and he did not mention any thoughts about suicide or self-harm.

25. The doctor said that he would not prescribe Mr Betteridge pregabalin until he had received confirmation from Mr Betteridge's community GP. He did not prescribe any of his other medication either. (A fax to a prisoner's community GP is normally sent the day after they arrive at the prison. However, Mr Betteridge had arrived on a Friday and, as it was a Bank Holiday weekend, confirmation would not arrive until the following Tuesday.) He said that Mr Betteridge became very demanding and he noted in the medical record that Mr Betteridge's behaviour was 'drug seeking'.

26. The doctor explained that, when prisoners bring medication with them, and it is legally labelled with the pharmacy address and phone number, healthcare staff treat this as their current medication, and can prescribe temporarily over a weekend or holiday period. However, Mr Betteridge did not have any evidence of his current medication.

27. The doctor did not record anything specific about opiate withdrawal but when interviewed said that he had seen no obvious signs of withdrawal symptoms. He told the investigator that Mr Betteridge had mainly been concerned about getting pregabalin. He referred Mr Betteridge for an assessment by the drugs and alcohol recovery team (DART) which, because of the Bank Holiday, would not take place until the following Tuesday.

28. At 2.20pm on Saturday 23 May, Mr Betteridge phoned his partner again. He told her that he was not sure what was going on in his head but officers had told him he could not see a doctor. His partner told him that he needed to ask again. The call lasted less that a minute. Mr Betteridge rang again at 2.32pm and said that he felt like he had had 'a load of cocaine'. He told his partner that he had been asking for pregabalin, but that he had been told he would not get it before Tuesday, as his community GP had to confirm the prescription. Mr Betteridge told his partner that his head was "battered" and he did not know what to do. He asked her to call his solicitor and ask them to make a bail application. He said that he was certain he would get bail as he had refused it initially.

29. There is no record that Mr Betteridge spoke to an officer about these concerns until at 8.00pm he pressed his cell call bell. He told the night patrol officer that he had not had any medication, and if he did not get it, he would harm himself. The officer recorded that Mr Betteridge's cellmate was also becoming 'worked up' by Mr Betteridge. He asked the duty nurse to see Mr Betteridge.

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30. The nurse spoke to Mr Betteridge through the cell door. She recorded that he seemed medically well, but was upset that his medications had been stopped. She told the investigator that she had seen no obvious signs of opiate withdrawal but Mr Betteridge had been unsettled and complained of a headache. She said that he talked about getting methadone rather than any other medications. She said that she had explained to him that the prison GP could not prescribe medication until his community GP confirmed his prescriptions.

31. At 10.34pm, the nurse recorded her interaction with Mr Betteridge that evening in his medical record retrospectively. In the record, she noted that she had gone to see him after he had threatened to hang himself, as he had not been prescribed methadone. She told the investigator that she had originally seen Mr Betteridge at about 8.30pm, and had gone back to his cell at least once after that, to give him paracetamol.

32. The nurse told the investigator that she thought that Mr Betteridge had mentioned hanging himself as a throw away comment to someone earlier. She said that after she and the night patrol officer spoke to him for a while, he was laughing and joking and had calmed down. Because of this, she had not taken any further action.

33. Later, officers asked Listeners, (prisoners trained by the Samaritans to offer confidential support to other prisoners) to come to the wing to see Mr Betteridge. The nurse said that two Listeners had arrived on the wing while she gave Mr Betteridge paracetamol.

34. At 12.05am on 24 May, Mr Betteridge's cellmate pressed the cell bell and told the night patrol officer that Mr Betteridge had made cuts to his chest. The nurse examined him and treated him. She said that the cuts were mostly superficial, but she had glued a deeper cut together. She said that Mr Betteridge was clearly agitated and was upset about a number of things, including medication and his family.

35. After Mr Betteridge had harmed himself, the night patrol officer began ACCT procedures. The night orderly officer (the duty manager in charge of the operation of the prison that night) went to the wing and completed an ACCT immediate action plan. He noted that Mr Betteridge should remain in the cell with his cellmate and staff should observe him once an hour. The night patrol officer checked him at 1.00am and 2.00am and recorded that Mr Betteridge was sitting or lying on the floor with a blanket over him. At 2.32am, the night patrol officer

asked the nurse to see Mr Betteridge again, as he was complaining of stomach pains and said that he had vomited blood.

36. When the nurse saw Mr Betteridge, he repeated these symptoms but then said that his stomach was 'just sore'. The night patrol officer told her that he was normally prescribed omeprazole (an antacid) for his stomach complaint. She said that she could see nothing about previous gastric issues in Mr Betteridge's medical notes from when he arrived.

37. The nurse said that she spent some time talking with Mr Betteridge, who calmed down. She said that she told him that she could not prescribe omeprazole, and that if he had vomited she did not want to prescribe anything that he might vomit back up.

38. At 4.00am, the cellmate pressed the cell bell and told the night patrol officer that Mr Betteridge had torn his sheet and made a ligature from torn bed sheets, which he had tied around the door handle. He said he had taken the ligature from Mr Betteridge, pressed the cell bell and handed it to the officer. He thought that Mr Betteridge was finding it difficult to cope, as he was withdrawing from drugs.

39. The night patrol officer said that he was concerned that the cellmate was becoming upset and did not want to be in a cell with someone who might harm himself. As well as the ligature, he said that he took the bed sheets that Mr Betteridge had been tearing up, as well as his belt. He did not ask the night manager to review Mr Betteridge's risk after this incident and continued to monitor him hourly.

40. At 6.25am on 24 May, day staff arrived for duty. An officer (it is not clear from the documents who this was) checked Mr Betteridge and recorded that he was sitting on a chair. His cellmate had complained that he had been kept awake all night as Mr Betteridge had been trying to 'string up'. The officer recorded that Mr Betteridge appeared in good spirits and asked him for a cigarette paper.

41. At 8.45am, an officer checked Mr Betteridge and noted in the ACCT document that he had said he had no intention of harming himself that day, but that he had wanted to die during the night because of 'pain'. Mr Betteridge told the officer that he had cut himself because of issues with methadone.

42. A Supervising Officer (SO), who was the manager on F Wing on 24 May, told the investigator that he had spoken to Mr Betteridge around 10.00am, when he had unlocked him for some time in the exercise yard. Mr Betteridge had asked for his belt back, but the SO said that he could not return it. He explained that this

would be considered at an ACCT assessment and case review later. The SO said that the cellmate had told him that Mr Betteridge was better and Mr Betteridge had agreed that he was fine. He advised Mr Betteridge to stay on the wing and not to go out for exercise so they could complete the ACCT assessment. The cellmate told us that he did not recall speaking to the SO that morning, or telling anyone that he thought that Mr Betteridge was better.

43. At 9.45am, an officer saw Mr Betteridge to assess him as part of the ACCT procedures. He recorded that Mr Betteridge's current problems were withdrawal from heroin and that he had been unaware of the support that was available to him, which had left him fearful. Mr Betteridge told the officer that he had harmed himself once in the past, when he was 17. He said he now felt much better, as wing staff and nurses had given him information about detoxification and had reassured him. He said that he no longer felt lost and had no current suicidal thoughts. He had three children and a grandchild to think of, and was looking forward to release and the future. However, he said he still felt unwell. The officer recorded Mr Betteridge did not have any current thoughts of suicide and that he would recommend that the ACCT document should be closed. When interviewed the officer said that he thought Mr Betteridge had engaged well, was very positive, had discussed the factors that would prevent him killing himself (such as his family) and came across as "massively reassured" by what he had been told about the support available for him.

44. After the ACCT assessment, an officer attended a case review with a SO. The SO did not ask anyone else to attend the review. Despite Mr Betteridge's problems with medication, there was no input from healthcare staff, although healthcare staff attendance at first ACCT case reviews is a mandatory requirement of ACCT procedures. The SO recorded that Mr Betteridge was now aware of the support available, such as from the drug and alcohol support team and detox nurses and he now felt reassured. He noted that Mr Betteridge had strong protective factors and said he did not have any thoughts of suicide and self-harm. They agreed to close the ACCT and gave Mr Betteridge his belt back.

45. The SO told the investigator that at the case review Mr Betteridge had said he had never attempted suicide before. He said that he could not recall having seen the officer's entry in the ACCT record that Mr Betteridge had said that he felt worse at night, had wanted to die and that his self-harm had been due to methadone issues. He said that Mr Betteridge had mentioned medication and that he had told Mr Betteridge that they could refer him to the GP. (Which they did not do.) The SO said they did not discuss the issues about his medication at any length. He said that Mr Betteridge really wanted the ACCT to be closed.

46. An officer recorded on Mr Betteridge's record that, after an assessment and review, staff had closed the ACCT. He recorded that Mr Betteridge had been 'rattling' badly (withdrawing from drugs) during the night and had been unaware of the support available. He was now happy that officers had explained the help available to him.

47. Later that morning, a healthcare support worker assessed Mr Betteridge for symptoms of withdrawal using the clinical opiate withdrawal scale (COWS). The COWS rates 11 common opiate withdrawal signs and symptoms. Mr Betteridge scored nine as he showed signs of sweating, restlessness, bone aches, stomach upset, tremor, yawning, anxiety, and gooseflesh. This indicated mild withdrawal. She recorded that Mr Betteridge was calm, pleasant and in a stable mood, although he appeared a little confused. She thought that this could be due to dehydration and advised him to drink more water. She noted that a nurse should review Mr Betteridge again later that day.

48. A nurse reviewed Mr Betteridge that afternoon and recorded that he did not show any signs of confusion. He advised Mr Betteridge to drink plenty of fluids and told him that he would organise symptomatic relief for withdrawal symptoms. There is no record that Mr Betteridge received any symptomatic relief.

49. At around 4.30pm, on 24 May, the cellmate moved cells at his own request. He told the investigator that a member of his family had taken their own life and that he had found it difficult being in the cell with Mr Betteridge when he had been suicidal the previous night. He said that Mr Betteridge was unhappy that he was moving cells, but said that he understood his reasons. He said that he had no further contact with Mr Betteridge.

50. An officer said that Mr Betteridge had told him that he understood why his cellmate had wanted to move. Mr Betteridge told the officer that he was feeling better, although he had had a rough day with his stomach. He said he was not receiving any treatment for his heroin addiction, but had an appointment to see the GP on 26 May. He told the officer that his life had gone downhill but he was turning it around and was feeling quite positive. He said that he wanted to get clear of drugs and win back his partner. The officer said that he had asked if there was anything he could do for Mr Betteridge, but he said that the talk had helped and that he was okay.

51. At 2.05pm on 25 May, a healthcare support worker assessed Mr Betteridge again. His COWS score was now zero, indicating that he had no symptoms of opiate withdrawal. Mr Betteridge complained of having a sore throat and stomach ache

and she asked a GP to see him. She said that Mr Betteridge did not indicate any thoughts or intentions of harming himself.

52. A doctor reviewed Mr Betteridge at 3.05pm, with Mrs Hopper. He recorded that Mr Betteridge had tried to hang himself and had cut his chest the day before. Mr Betteridge said he felt unwell and sometimes felt suicidal, but would not hurt his family by killing himself.

53. Mr Betteridge told the doctor that he had previously had a burst peptic ulcer and his community GP had prescribed omeprazole. The doctor recorded that Mr Betteridge was mentally stable with no evidence of psychosis or paranoia. He recorded that there was no signs that Mr Betteridge was restless, shivering or sweating, and he noted that he did not have gooseflesh (all signs of withdrawal from drugs). He noted that their conversation was normal and Mr Betteridge made good eye contact. Mr Betteridge had an inflamed throat, for which the doctor prescribed penicillin. He also prescribed omeprazole. This was the last recorded contact with Mr Betteridge. The doctor told us that, although he worked in several prisons, he had never been ACCT trained.

26 May

54. At 4.55am on 26 May, a night patrol officer was carrying out a routine security check and saw that Mr Betteridge had hanged himself from the cell light fitting. He immediately radioed the orderly officer and asked him and his assistants to attend F Wing for ‘a ligature’. He did not use a standard medical emergency code, which would have alerted healthcare staff and prompted the control room to call an ambulance. An officer was on F2 landing when he heard the night patrol officer’s message and said that he arrived at the cell about a minute later. The night patrol officer opened the door and supported Mr Betteridge’s body while the officer cut the belt, from which Mr Betteridge was hanging. The belt was threaded between the ceiling and the back of the cell strip light. They lowered Mr Betteridge’s body to the floor.

55. A custodial manager was the orderly officer that night and went to F Wing with two officers. He said that they arrived at the cell around two minutes after the radio call. The officer and night patrol officer were standing on the landing outside the cell. Mr Betteridge was on the floor near the door. The custodial manager believed that he had then radioed a code blue emergency. The officers had not attempted life support and he said that it was clear when he looked at Mr Betteridge that he was dead. It was evident from his position that rigor mortis was present as his hip was on the floor but his head and ankles were six inches

from the ground. He said that he then went to the landing office to telephone the control room.

56. The control room officer said that she had been out of the room for a while and when she came back her support colleague said that there had been a code blue. She said that the custodial manager had radioed and said that he would contact her by telephone. He telephoned and, at 5.04am, told her to call an ambulance. He said that they had not started resuscitation.

57. Two nurses arrived and attached a defibrillator to Mr Betteridge, which found no shockable heart rhythm. When the custodial manager came back to the cell, the nurses had started cardiopulmonary resuscitation and he informed the control room officer. She believed she had updated the ambulance service, as she was on the phone to them at the time. However, there is no record of this in the ambulance log. The nurses continued to attempt resuscitation for 40 minutes until paramedics arrived at 5.40am. The paramedics found that Mr Betteridge was clearly dead as there were signs of rigor mortis and hypostasis (pooling of blood). At 5.46am, they recorded that Mr Betteridge had died.

58. Mr Betteridge left a letter in his cell addressed to his partner, in which he apologised for his actions. He said that he had not received the medication he had been prescribed in the community. He made it clear that he was not referring to methadone.

Contact with Mr Betteridge's family

59. Mr Betteridge had named his partner as his next of kin when he arrived at Durham. Two prison chaplains went to see Mr Betteridge's partner at her home on the morning of 26 May and informed her of his death and offered condolences. Mr Betteridge's partner gave them a telephone number for Mr Betteridge's mother but one chaplain was unable to contact her on that number. He spoke to Mr Betteridge's mother the next day, after the police had helped to trace her. In line with Prison Service instructions, the prison contributed to the costs of the funeral.

Support for prisoners and staff

60. After Mr Betteridge's death a prison manager debriefed the staff involved in the emergency response to give them the opportunity to discuss any issues arising, and to offer his support. The staff care team and chaplaincy also offered support. The safer custody team reviewed all prisoners assessed as at risk of suicide and

self-harm, in case they had been affected by Mr Betteridge's death. Staff offered Mr Betteridge's former cellmate additional support.

Post-mortem report

61. The post-mortem examination confirmed that the cause of death as suspension. Toxicology tests found no potentially fatal concentrations of medication in Mr Betteridge's system.

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Findings

Assessment and management of risk of suicide and self-harm risk

62. We have considered whether reception staff should have identified that Mr Betteridge was at risk of suicide and self-harm when he first arrived at Durham. The only information they had was the documents they received from court, which did not highlight any recent concerns about suicide or self-harm. His alleged offence of theft was not one that would usually indicate an increased risk of suicide and self-harm and Mr Betteridge did not report any thoughts of suicide and self-harm. Mr Betteridge reported a history of depression and anxiety for which he had been prescribed medication but a doctor assessed him that evening and did not observe any signs of anxiety. He did not have obvious signs of opiate withdrawal.

63. Mr Betteridge was worried about not receiving his medication, particularly pregabalin to treat anxiety. The first days in prison are a stressful time for all new arrivals, and, with hindsight, it might have been advisable to begin ACCT procedures as a precaution until Mr Betteridge settled and received his medication. However, this was a matter of judgement and we do not consider that there was an overriding reason for staff to have begun ACCT procedures when Mr Betteridge first arrived.

64. On 23 May, Mr Betteridge said that he would harm himself if he did not get medication. The night patrol officer and a nurse spoke to him and thought he had calmed down. While this was not explicitly recorded, it appears that they did not consider he was at risk of suicide or self-harm at the time. In the early hours of 24 May, the patrol officer appropriately opened an ACCT, after Mr Betteridge self-harmed by cutting his chest and stomach.

65. However, we are concerned that after this, Mr Betteridge's risk was not well managed. After he cut himself in the early hours of 24 May, he continued to try to harm himself and his cellmate prevented him from hanging himself by a ligature. Staff removed the ligature and other items he might use to make other ligatures such as his belt and sheets. However, the night patrol officer did not consult the orderly officer to reassess his level of risk or increase the level of observations, despite this evident increase in suicidal behaviour. A nurse said that she was unaware that Mr Betteridge had made ligatures.

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66. The officer who assessed Mr Betteridge on 24 May, is a member of the Safer Custody department at Durham, and trains staff in ACCT procedures. After his assessment, he recorded that Mr Betteridge would apply to speak to the detoxification and DART teams about his substance misuse issues but he recommended that they should end ACCT procedures as he did not consider Mr Betteridge was at risk any longer. The SO who chaired the ACCT case review with the officer, simply recorded that Mr Betteridge was now aware of support available and felt reassured. There was no member of healthcare staff present, although this is a mandatory requirement for first ACCT case reviews. There was no consideration of Mr Betteridge's medication and substance misuse issues at the case review.

67. Mr Betteridge had not yet been assessed by the drug and alcohol team and had not received the medication he usually took because he had arrived immediately before Bank Holiday weekend. The SO did not refer Mr Betteridge to any services and left it Mr Betteridge to follow this up himself. Although Mr Betteridge had cut himself in the early hours of that morning and had subsequently threatened to hang himself and tied ligatures less than eight hours earlier, the SO and officer decided that Mr Betteridge was no longer at risk and ended the ACCT procedures. We are not satisfied that the review appropriately followed the guidance in Prison Service Instruction (PSI) 64/2011 to identify the prisoner's most pressing needs, how the prisoner will be supported and whether a referral for mental health care or drug/alcohol services is needed.

68. The PSI states that it is a mandatory action for all staff in contact with prisoners to have received 'Introduction to Safer Custody' – ACCT training. A doctor told us he had not been trained. A nurse also said that she had not completed her ACCT training when she saw Mr Betteridge, although she had been working at Durham for nearly two months.

69. We consider that the ACCT case review did not appropriately identify Mr Betteridge's concerns or address them. The ACCT was closed too soon and the procedures were not in line with Prison Service national instructions. We make the following recommendation:

The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidance, including:

- **A multi-disciplinary approach for all case reviews.**
- **Healthcare staff attending all first case reviews.**

- **Reviewing levels of observations whenever an event occurs which indicates an increase in risk.**
- **ACCT plans are not closed shortly after incidents of self-harm, unless there is clear evidence that the prisoner is no longer at risk and all issues identified at the assessment interview have been resolved.**
- **All staff in direct contact with prisoners have ACCT training.**

Clinical care

70. The clinical reviewer commented that, although Mr Betteridge said he had used opiates and tested positive for them when arrived at Durham, he displayed only limited signs of withdrawal when he first was first assessed, and none when he was assessed on 25 May. He was satisfied that, there was little evidence that Mr Betteridge was suffering from opiate withdrawal and there was nothing to indicate that he needed to be prescribed methadone as an opiate substitute.

71. Mr Betteridge was very concerned that he did not receive pregabalin that he said that he had been prescribed in the community for anxiety. We were concerned that this left Mr Betteridge without any medication for anxiety for some days, but the clinical reviewer said that it is normal practice not to re-prescribe medication without first confirming the prescription with a community GP. It is unfortunate that Mr Betteridge arrived at Durham at the start of a Bank Holiday weekend, when the GP surgery was unlikely to be open. The prison sent a fax requesting confirmation of Mr Betteridge's prescriptions, but there was little chance of this being returned before the following Tuesday.

72. The clinical reviewer considered that the prescribing practice for Mr Betteridge's clinical care was in line with that he might have expected in the community, had he been away from his usual GP without his medication. A GP unfamiliar with Mr Betteridge in the community would not have re-prescribed his medication without first confirming this with his home GP.

Emergency response

73. Prison Service Instruction 3/2013 requires governors to have a medical emergency response code protocol, which ensures that an ambulance is called immediately in a life-threatening medical emergency. Durham has an appropriate emergency protocol. The PSI also states that all prison staff must be made aware of and understand the protocol and their responsibilities during medical emergencies.

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74. The night orderly officer did not use a medical emergency code when he radioed the control room for help, after finding Mr Betteridge hanging. Instead, he said that he had 'a ligature on F Wing'. We are satisfied that this did not delay the initial emergency response, which was fast and effective, but it meant that the nature of the emergency was not communicated effectively to all relevant staff and the control room did not call an ambulance immediately as would usually happen. When he called for help he was unaware whether resuscitation would have been possible. In this case it made no difference to the outcome as it was apparent that Mr Betteridge was already dead but in other emergencies such a delay could be critical. We, therefore, make the following recommendation:

The Governor should ensure that all staff are aware of and use the appropriate emergency response code in a life-threatening situation and that the control room calls an ambulance immediately.

Resuscitation

75. A nurse said that he had not been trained to recognise rigor mortis and therefore followed medical procedure and began CPR. The clinical reviewer noted that the policy at Durham appears to be that healthcare staff should continue CPR until a prison GP or paramedics pronounce death.

76. We consider that it was not necessary to attempt to resuscitate Mr Betteridge. European Resuscitation Council Guidelines 2010 state, "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile …" The guidelines define examples of futility as including the presence of rigor mortis. More recently, the British Medical Association (BMA), the Royal College of Nursing (RCN) and the Resuscitation Council (UK) issued guidance in October 2014 about making appropriate decisions about resuscitation. The guidance says that every decision should be made on the basis of a careful assessment of each individual's situation. Decisions should never be dictated by 'blanket' policies.

77. We understand that the natural inclination of healthcare staff is to begin emergency first aid by giving life support but attempting resuscitation when someone is clearly dead is distressing for staff and undignified for the deceased. We make the following recommendation:

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The Head of Healthcare should ensure that healthcare staff are given clear guidance and training, in line with established professional guidelines, about the circumstances in which resuscitation is inappropriate.

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141