PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man in November 2014 at HMP Holme House.

Our Vision

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

This is the investigation report into the death of a man, who was found hanged in his cell at HMP Holme House on 8 November 2014. I offer my condolences to the man's family and friends.

On of my investigators and a clinical reviewer reviewed the man's clinical care at Holme House. The prison co-operated fully with the investigation.

The man was remanded to Holme House on 3 November 2014. The prison was outside his home area in the North West, but all local prisons in that region were full at the time. The man had previously attempted suicide and had been admitted to psychiatric hospitals. He had taken an overdose just a few days previously. He suffered from depression and had alcohol problems. When he arrived at Holme House, prison staff identified that he was at risk of suicide and self-harm, began support procedures and admitted him to a single cell in the prison's healthcare unit.

Staff assessed the man as a high risk to himself and, the day after he arrived, began to monitor him constantly. On 5 November, he said he disliked constant supervision, as it stopped him harming himself. On 6 November, even though he said that he still had suicidal thoughts and despite his comments from the day before, staff assessed his risk of suicide and self-harm as low and reduced the level of required observations to once an hour. In the early hours of the morning, a night patrol officer found the man hanged in his cell.

I am satisfied that staff appropriately identified the man as at risk of suicide when he arrived at the prison. However, I am concerned that staff, at a case review on 6 November, assessed his level of risk as low, a decision that was clearly at odds with what he had reported during his short time at the prison. Sadly, the consequent reduction in the level of observations gave the man the opportunity to kill himself, which he had clearly been planning. Risk assessment is inevitably dependent on professional judgment, but as I have previously found at Holme House, staff appear to have placed too much reliance on the man's presentation, rather than on his known risk factors.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **June 2015**

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SUMMARY

1. Preston Crown Court remanded the man to prison on 3 November 2014. Prisons in the North West were full, so the man was sent to Holme House in Teesside. He had a history of mental illness and alcohol problems. Three days before, on 31 October, he had tried to kill himself by taking an overdose.

2. Court and escort staff completed a suicide and self-harm warning form, which they gave to reception staff at Holme House. When the man arrived at the prison, he was tearful and extremely remorseful. A reception nurse noted his risk factors and began Prison Service suicide and self-harm prevention procedures, known as ACCT. She admitted him to the prison's healthcare unit.

3. On 4 November, staff assessed the man as a high risk of suicide and began to monitor him constantly in a gated cell to aid observation. The next day, he said that he disliked being constantly supervised as it stopped him from harming himself. At a review on 6 November, the man said he still had fleeting thoughts of suicide. Despite this, his comments the day before, and his evident risk factors, the staff assessed his risk of suicide and self-harm as low and reduced his observation level to one each hour. He moved to a standard cell in the healthcare unit, which contained a moveable bed.

4. At 2.10am on the night of the man's death, a night patrol officer found the man had hanged himself by torn sheets attached to the upturned bed. He radioed a medical emergency code, which signalled the control room to call an ambulance immediately. The officer went quickly into the cell with another officer and a nurse. The officers cut the ligature and laid the man on the floor. The nurse found no signs of life and began cardiopulmonary resuscitation, which staff continued until paramedics arrived and took over his care. At 2.35am, the paramedics pronounced the man dead.

5. Prison staff correctly identified the man as at risk of suicide and self-harm procedures when he arrived at Holme House and began to monitor him. However, we consider that the decision to reduce the level of observations from constant supervision to one each hour was taken too soon. There was little to indicate that his risk of suicide had significantly reduced and the decision did not take fully into account the man's risk factors, his comments the previous day and other evidence, which indicated his high risk.

THE INVESTIGATION PROCESS

6. The investigator issued notices to staff and prisoners at HMP Holme House informing them of the investigation and inviting anyone with relevant information to contact her. No one responded.

7. On 19 November, the investigator visited Holme House and obtained the man's prison and clinical records. She visited the healthcare unit and spoke to the Head of Safer Prisons and Equality. She interviewed staff on 2 December, and gave the Governor initial feedback on her findings.

8. The investigator contacted Cleveland police and discussed a reconstruction of the man's death that the police had conducted.

9. The clinical reviewer carried out a clinical review, commissioned by NHS England.

10. We informed HM Coroner for Teesside of the investigation, who provided the results of the post-mortem examination. We have sent the coroner a copy of this report.

11. One of the Ombudsman's family liaison officers contacted the man's family. They raised a number of issues that they wanted the investigation to consider:

    - How had the man killed himself?
    - How had he managed to lift a heavy hospital bed?
    - Why did nobody hear the bed being moved?
    - Was the man withdrawing from his mental health medication?
    - They said that they had difficulty contacting the prison's family liaison officer on several occasions.

12. The man's family received a copy of the draft report and indicated that they agreed with the findings.

HMP HOLME HOUSE

13. HMP Holme House is a local prison holding over 1200 men. Care UK provides health services at the prison. There is a 24-hour inpatient unit with 28 beds and palliative care facilities.

HM Inspectorate of Prisons

14. The most recent inspection of Holme House was in August 2013. Inspectors reported that the prison faced significant challenges, but had made some important progress since their last inspection in 2010. However, they were concerned that the prison had not sustained previous progress made in learning about risk indicators associated with self-inflicted deaths. Inspectors considered that care for prisoners who had been assessed as at risk of suicide or self-harm was good.

Independent Monitoring Board

15. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community to help ensure that prisoners are treated fairly and decently. In the latest IMB annual report, for the year to December 2013, the IMB were satisfied that the quality of general healthcare was good. The IMB noted that mental health provision was of a high standard. The IMB commended the Safer Prisons and Equality team for the care they showed to prisoners managed under suicide and self-harm procedures.

ACCT - Assessment Care in Custody and Teamwork

16. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be irregular to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves drawing up a care map to identify the prisoner's most urgent issues and how they will be met. Regular multi-disciplinary reviews should be held. The ACCT plan should not be closed until all of the actions on the care map have been completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Previous deaths at Holme House

17. Since 2011, there have been seven self-inflicted deaths at Holme House, six of which happened during the prisoners' early days at the prison. We have made several recommendations about the need for better risk assessments and improved support during those early days. In our report into the most recent self-inflicted death, which occurred in May 2014, we made a recommendation about the operation of ACCT, including about an inappropriate reduction in the level of observations. Similar issue arose during this investigation.

KEY EVENTS

18. The man appeared at Preston Crown Court on 3 November 2014, charged with assault against his partner. He lived in Lancashire, but prisons in his home area, which take prisoners directly from court, were full at the time, so he was taken to HMP Holme House, in the North East.

19. The man had been dependent on alcohol, but had stopped drinking for 21 months before recently relapsing because of the emotional impact of finding a friend dead. Three days before his arrest, he had taken an overdose of temazepam tablets, which had been prescribed by his doctor. He told officers at court that he wanted to kill himself. A court custody officer completed a suicide and self-harm warning form stating that the man wanted to "end it all". Staff observed him six times an hour while he was at court.

20. The man arrived at Holme House at 7.05pm, on 3 November. The escort officers gave Officer A and Officer B in reception the suicide and self-harm warning form and his Person Escort Record (PER).

21. Soon after the man arrived at Holme House, Nurse A carried out a reception health screen and noted the suicide and self-harm warning form and the nature of the man's offence. (Prisoners charged with or convicted of violent offences, particularly against family members are recognised to be at greater risk of suicide. In a PPO thematic report, "Risk factors in self-inflicted death in prisons", published in 2014, we found that 26% of prisoners who killed themselves had been charged or convicted of an offence of domestic violence.)

22. Nurse A noted that the man was very tearful and in a very low mood. The man told her that he was ashamed and very sorry for what he had done. He said that he had previously tried to kill himself and had been admitted to psychiatric hospitals. He had been diagnosed with depression and had taken an overdose on 31 October. The nurse considered that the man was at risk of suicide and self-harm and began ACCT procedures at 9.00pm.

23. Nurse A told the man that he would remain in the healthcare unit for observation. She completed an immediate action plan and required staff to observe him at least twice an hour until a member of staff assessed the man. She explained that Listeners (prisoners trained by the Samaritans to support other prisoners) were available if he wanted to speak to one. The nurse referred the man to the mental health team.

24. Nurse B, from the mental health team, assessed the man at 9.00am on the morning of 4 November. She recorded that he was dishevelled, anxious and tired, but showed no evidence of psychosis. She noted that he was still feeling suicidal, but he said that had no plans to act on these feelings and would use his cell bell to call for someone if he felt worse. She allocated a mental health caseworker to support him and told him about the chaplaincy's counselling services.

25. Nurse C saw the man for a second health screen later that morning. The man told her that over the past three weeks he had been drinking five to six litres of cider a day. She arranged for Dr A to prescribe him diazepam (an anti-anxiety medication used to alleviate the symptoms of alcohol withdrawal) on a reducing dose over seven days, and venlafaxine (an anti-depressant) which the man said that he had been taking in the community.

26. At 12.30pm, Nurse D assessed the man as part of the ACCT procedures. The man explained how two recent bereavements had emotionally affected him. He said that he felt extremely ashamed about his behaviour towards his partner and felt that he had lost everything and wanted to die. The nurse noted these key issues in the ACCT document. In the summary of the assessment the nurse wrote that the man should remain in the healthcare unit, the chaplain should talk to him, the doctor should prescribe him medication and someone from the mental health team should see him.

27. Nurse E chaired the first ACCT case review at 3.20pm, with the man, and healthcare assistant, A. Nurse D did not attend. Nurse E told the investigator that before the review she had found the man in his cell in a very agitated state. He was crying and had made ligatures out of the bed sheets in his cell.

28. Nurse E assessed that the man was at raised risk of suicide and self-harm and she increased his observations to four each hour, while she arranged for a further review with a manager and a member of the mental health team to discuss whether staff should constantly supervise him. The nurse wrote two actions on his ACCT caremap: for the man to take his medication and for him to see a psychiatrist. The man remained in the healthcare unit.

29. At 4.10pm, Nurse E chaired an urgent case review with the Head of Safer Prisons and Equality, Nurse F, a member of the mental health team, and the prison chaplain. The man told them that he did not feel safe, could not control his feelings and wanted to kill himself. They assessed his risk of suicide as high and decided he should be constantly supervised. They added two more actions to the caremap: for the man to engage with the mental health team and for someone from the chaplaincy to speak to the man.

30. The chaplain, spoke to the man at 5.10pm. The man said that the police had kept his mobile phone, which meant that he did not have contact details for his family and friends. He was upset that he was a long way from his home area. The chaplain agreed to try to find the contact details.

31. On 5 November, the Head of Security chaired another ACCT review with Nurse F, the healthcare manager, Officer C and the prison chaplain. The man said he was having unpleasant thoughts and was angry about being constantly supervised because it was stopping him from harming himself. He said that he was hearing a voice that was shouting and abusing him.

32. The ACCT review assessed the man as at high risk of suicide and self-harm and decided to continue constant supervision. The staff advised the man about distraction techniques to relieve his anxiety and moved him to a gated cell in the healthcare unit, to allow staff to supervise him more easily.

33. On the morning of 6 November, Officer D took the man outside the unit for a walk. He recorded in the ACCT document that the man had communicated well with him and discussed his upcoming court case and his past. The officer noted that the man seemed to have a more positive outlook.

34. At 9.45am, Nurse E chaired another ACCT review, with Nurse F and the Head of Residence and Safety. She noted that the man appeared calmer. He said that he still had fleeting thoughts of suicide but felt a lot stronger and would talk to staff if he felt worse again. He said that he had written letters to his family and friends and was waiting to get their telephone numbers.

35. The ACCT review assessed the man's risk of suicide and self-harm as low and reduced his observations to one each hour. The investigator asked Nurse E whether they had considered reducing the man's observations more incrementally. The nurse said that it had been a multidisciplinary decision and that she did not regard four observations an hour as a step-down from constant observations, as it would suggest that the prisoner was still in crisis. She said that cells in the healthcare unit were open for most of the day, staff could see the man a lot of the time, and he spent time out of his cell playing Scrabble or cards with other prisoners, which she thought would help him.

36. The man moved from the constant supervision cell to a cell further down the corridor. Nurse E told the investigator that one side of the healthcare unit housed prisoners with mental health problems and the other side, those with physical illnesses. She decided that it would be better for the man to have a cell on the side for prisoners with physical illnesses because it was quieter and she thought that would be better for him.

37. The only vacant cell had a large, moveable, bariatric bed in it. (A bariatric bed has a heavy mattress and can be moved, raised or tilted electronically.) The investigator visited the cell and saw the bed. She was unable to lift it. Nurse E told the investigator that, although the bed was moveable, it was very heavy and more comfortable than a standard bed. She said that the man was now regarded as a low risk of suicide and self-harm and seemed much more settled. She would usually be more worried that patients would damage the bed rather than use it to harm themselves. The man had agreed that he would prefer to be in the quieter area with a more comfortable bed.

38. Around 4.15pm, a second chaplain at Holme House, saw the man and gave him contact details for his friends and family. The man completed an application to add the numbers to his prison phone account, which would allow him to call them.

39. The ACCT ongoing log indicated that staff considered that the man seemed settled through the day on 7 November. He mixed with other prisoners and

joined in activities. A number of staff who supervised the man noted in the log that he was writing long letters when he was in his cell.

40. At 9.00pm on 7 November, night patrol officer A took over responsibility for the man's observations. The ACCT record indicates that he first checked the man at 9.00pm, when the man said that he was okay. The night patrol officer checked him again at 9.50pm, 10.50pm, 11.30pm, midnight and 1.15am. At the 1.15am check, the night patrol officer recorded that the man was still awake watching television.

41. The night patrol officer next went to check the man at 2.06am. (He said that this was according to the time on his watch.) He looked through the observation hatch and saw the man hanging from a ligature made of torn sheets, tied to the upended bed. He immediately radioed a code blue emergency and asked the emergency nurse to attend. (A code blue is an emergency medical code used in circumstances such as when a prisoner is unconscious or not breathing. It should alert control room staff to call an ambulance immediately and healthcare and other staff to respond urgently with appropriate emergency equipment.) It was recorded in the control room log that nigh patrol officer called the code blue at 2.10am.

42. Officer E was constantly supervising another prisoner further along the corridor in the healthcare unit. When he heard the code blue, he checked that the prisoner he was supervising was asleep, and went to help the night patrol officer. Nurse G, who was in the healthcare unit, went immediately to the man's cell.

43. For security reasons, at night only the orderly officer in operational charge of the prison carries a full set of keys. Other officers carry a cell key in a sealed pouch for use in an emergency. Officer E used his emergency key and went into the cell with the night patrol officer and Nurse G.

44. The night patrol officer supported the man's weight while Officer E cut the ligature. The officers placed the man on the cell floor and Nurse G checked him, found no signs of life and started cardiopulmonary resuscitation. Other staff brought an oxygen bag and a defibrillator. (A defibrillator is a life-saving device that gives the heart an electric shock in some cases of cardiac arrest to re-establish a normal heart rhythm.) The staff continued to perform chest compressions while the nurse administered oxygen. The nurse attached the defibrillator to the man, but this did not detect a shockable rhythm. (The officer had resumed his constant supervision of the other prisoner, as soon as other staff arrived.)

45. According to the control room log and a handwritten log, which a member of staff completed at the scene, control room staff called an emergency ambulance at 2.11am. The ambulance arrived at 2.27am. At 2.28am, paramedics took over emergency treatment but, at 2.35am, they pronounced the man dead.

46. Staff told prisoners in the unit, who were awake at the time, what had happened and offered them support. The Governor issued a notice informing all prisoners about the man's death and offering them support from Listeners or Samaritans if they needed it. At 5.40am, the duty governor debriefed the staff who had been involved in the emergency response. The duty care team offered them support. Staff reviewed prisoners who were being managed under ACCT procedures, in case they had been affected by the news of the man's death.

47. The man had not named any next of kin when he arrived at Holme House. Although the prison chaplain, A had found an address for the man's son, this was not on his prison record so no one was able to contact his family immediately. At 8.30am on 8 November, the prison's family liaison officer, found the man's son's address and gathered information about the circumstances of the man's death. She and the governor left the prison at 10.00am to inform the man's son of his death. They arrived at his house at 12.04pm and at first could not get an answer. Eventually the man's son came to the window but refused to speak to them.

48. The family liaison officer and the governor knew where the man's son's mother worked and went there and broke the news to her. The man's family then gathered at a family member's home and the family liaison officer and the governor explained further, what had happened.

49. A second family liaison officer later spoke to the man's family about the arrangements for his funeral. She arranged for the man's family to visit the prison and see where he had lived. She also organised transport for them to attend the opening of the inquest. The prison paid funeral costs in line with national guidance.

50. The police removed some letters from the cell. They were addressed to the man's partner, his son and the prison and indicated that the man intended to kill himself.

51. Detective Sergeant from Cleveland Police visited the prison after the man's death. He told the investigator that he had looked at how the man had lifted up the bed and whether Officer E who was the nearest member of staff to the cell at the time, could have heard him from further along the corridor. He concluded that the man had been able to lift the bed by himself, and that it was unlikely that the office would have heard him doing so.

Post-mortem

52. The post-mortem report showed that the man died from cerebral anoxia (lack of oxygen to the brain) as a result of hanging.

ISSUES

Clinical care

53. The clinical reviewer concluded that the man's standard of healthcare for the short time that he was at the prison, was generally equivalent to that he could have expected to receive in the community. The reception nurse had identified that the man was at risk of suicide and opened an ACCT appropriately. The man received appropriate medication for depression and alcohol withdrawal. The clinical reviewer noted that, while it was more usual to prescribe chlordiazepoxide for alcohol withdrawal in prison, in this case diazepam was appropriate, as the man had been taking diazepam before he came to prison. The clinical reviewer also identified some learning points for the future, which the Head of Healthcare will need to address. These included risk assessing healthcare cells to decide which are suitable for prisoners with suicidal behaviours

Assessment of risk of suicide and self-harm

54. Court and escort staff had identified the man as a risk of suicide or self-harm before he arrived at the prison. Although we note that the reception nurse at Holme House did not sign the suicide and self-harm warning form, as she should have done in line with Prison Service policy, she saw the warning form and recognised that the man had several risk factors to indicate that he was at increased risk of harming himself. She immediately began ACCT suicide and self-harm procedures, which was appropriate.

55. On 4 November, a nurse found the man crying in his cell and discovered that he made ligatures from a torn bed sheet. A multidisciplinary case review assessed that the man was at high risk of suicide and self-harm and decided that he should be constantly supervised in a gated cell (where the end wall and door consist of bars and a gate to allow maximum visibility into the cell). The next day, 5 November, the man said that he did not want to be constantly supervised as this prevented him from harming himself. At a review the day after, he said he still had fleeting thoughts of suicide, but the review decided that he was at low risk of suicide and self-harm and reduced his level of observations to one an hour. Guidance on the ACCT form indicates that when a prisoner has frequent ideas of suicide, has a mental disorder, has previously attempted suicide, and demonstrated self-harming behaviour, staff should assess them as a raised risk.

56. We do not consider that the assessment of the man's risk of suicide and self-harm on 6 November was appropriate. The man had been charged with a violent offence against a close family member, he had taken an overdose in an attempt to kill himself less than a week previously, he was withdrawing from alcohol, he had a history of psychiatric problems and previous suicide attempts, he suffered from depression, had experienced recent bereavement and had told court staff just three days previously that he wanted to kill himself. All of these are factors that indicated he was at risk of suicide. Taken together, they would suggest his risk was high. Since he had arrived at the prison, a nurse

had found him with ligatures on 4 November. On 5 November, he had made it clear that he would harm himself if he had the opportunity. On 6 November, he said he said he still had fleeting thoughts of suicide.

57. Although the man had been at the prison only three days, and despite the factors outlined above, the staff at an ACCT review on 6 November observed that the man seemed more positive and calm that day, assessed his risk of suicide and self-harm as low and decided to reduce the level of observations to one an hour. Prison Service Instruction 64/2011 indicates that one of the aims of case reviews for prisoners under constant supervision is to reduce the level of supervision progressively. We consider that any improvement in mood was so recent that it was insufficient reason to reduce the level of observations so drastically at that stage. Just the day before, the man had indicated his frustration that constant supervision prevented him from harming himself and it seems likely that he had recognised that he needed to persuade the staff that he felt better, in order to have the level of supervision reduced.

58. In a recent investigation into another self-inflicted death at Holme House, we noted that staff had reduced the level of observations too soon after the prisoner had arrived. As we have found in other cases, staff were too reliant on the man's presentation on 6 November and did not give sufficient weight to his range of risk factors when assessing his level of risk and reducing the level of observations. 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 guidelines, including:

- **Taking full account of all known risk factors when determining a prisoner's risk of suicide or self-harm and fully recording reasons for decisions;**
- **Reducing the level of supervision progressively for prisoners who have been constantly supervised and providing alternative support as the prisoner's condition improves; and**
- **Setting levels of observations that properly reflects the prisoner's level of risk.**

59. We have considered whether the man's level of risk meant that he should have been allocated a cell with a bed that he could move. As outlined above, our main concern is the assessment that the man was at low risk of suicide and self-harm on 6 November. Had he been regarded as at high risk, then moving him to a cell with a movable bed with relatively long gaps between observations would have been inappropriate. As he was assessed as low risk on 6 November, there was little reason for staff to consider that he needed a cell with fixed furniture. Were it not for the flawed risk assessment, it was reasonable to consider that a more comfortable bed in a quiet part of the healthcare unit might help the man feel better.

Informing the man's family

60. Paramedics pronounced the man dead at 2.35am. As there were no next of kin details recorded when the man arrived at Holme House, staff were unable to establish who to contact.

61. Although a chaplain had previously found the man's son's contact details when helping him to find telephone numbers for his friends and family, the information was not on the prison's computer records. Unfortunately, this led to a delay before the man's family were informed.

62. The man's family told our family liaison officer that they had tried to contact the family liaison officers at Holme House a number of times in the week after the man died, in order to make arrangements to view his body and for his funeral, but could not get hold of them. The two family liaison officers told the investigator that they were not aware of any unanswered messages or phone calls. We have been unable to establish why there seems to have been a communication breakdown, but are satisfied that the prison arranged for the man's family to view his body and other liaison with his family appears to have been good.

RECOMMENDATIONS

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

    - Taking full account of all known risk factors when determining a prisoner's risk of suicide or self-harm and fully recording reasons for decisions;
    - Reducing the level of supervision progressively for prisoners who have been constantly supervised and providing alternative support as the prisoner's condition improves; and
    - Setting levels of observations that properly reflects the prisoner's level of risk.