Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Scott Page a prisoner at HMP Durham on 14 August 2017

A report by the Prisons and Probation Ombudsman

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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.

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

Mr Scott Page was found hanged in his cell at HMP Durham on 14 August 2017, two days after he was remanded to custody. He was 45 years old. I offer my condolences to Mr Page's family and friends.

Staff began monitoring Mr Page under suicide and self-harm prevention procedures on the day he arrived at Durham, but they stopped the following day after he said he would not harm himself. The investigation found some minor weaknesses in the operation of the suicide and self-harm prevention procedures as well as the emergency response, although we do not consider that these deficiencies affected the outcome for Mr Page.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman **April 2018**

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Summary

Events

1. Mr Scott Page was remanded to HMP Durham on 12 August 2017 for allegedly breaching his Sex Offender Prevention Order and for possession of class B drugs.

2. Later that day, Mr Page's cellmate told an officer that Mr Page was talking about taking his own life. The officer started suicide and self-harm monitoring (ACCT procedures) and Mr Page was observed at hourly intervals throughout the night.

3. On the morning of 13 August, another officer saw Mr Page for an ACCT assessment interview. Mr Page told the officer that he was ashamed of what he had done and he had been feeling low about returning to prison. Mr Page said that he would not do anything to harm himself as he did not want to hurt his family. Later that day, Mr Page had his first ACCT review which was attended by the mental health team. Mr Page repeated that he had no intention of harming himself. Those present assessed his risk as low and agreed to stop ACCT monitoring.

4. On 14 August at 1.45pm, Mr Page attended induction with a Prisoner Information Desk (PID) worker. The PID worker said Mr Page was upbeat and cheerful and he had no concerns about him when he left to return to his cell at approximately 2.30pm.

5. At approximately 4.15pm, Mr Page's cellmate returned from work to find Mr Page hanging by a sheet from the end of the bunk bed with a pillowcase and a bag on his head. He called for staff assistance and officers attended. They cut the ligature and immediately radioed an emergency medical code. Officers started cardiopulmonary resuscitation (CPR) until healthcare staff arrived and took over a few minutes later. Paramedics arrived at approximately 4.38pm and continued attempts to save Mr Page's life. These were unsuccessful and at approximately 5.05pm, Mr Page was pronounced dead.

6. Mr Page left a number of notes in his cell in which he made clear that it was his intention to take his own life and to make others believe otherwise. He specifically asked that no staff members were blamed for his death as everyone had treated him with compassion and professionalism.

Findings

7. Overall, prison staff delivered a good standard of care to Mr Page and acted appropriately when there was an indication that he was at risk of self-harm. We do not consider that staff could have known that Mr Page was at imminent risk of suicide at the time he died and we acknowledge that he was convincing in his denial of self-harm. We consider that he made a determined and well-planned effort to take his own life, and it is unlikely that his death could have been prevented.

8. There were some weaknesses in the ACCT procedures, namely, the predictability of observations, the absence of a caremap and some minor errors

on the ACCT documentation. We do not consider that these issues would have changed the outcome for Mr Page but, if not addressed, they may impact on the outcome for other prisoners assessed as being at risk of suicide and self-harm in the future.

9. There were some weaknesses in the emergency response, particularly that the appointed medical responder arrived at Mr Page's cell without any medical equipment, despite the correct emergency code having been called.

10. Some staff involved in the emergency response were not invited to attend a debrief and did not feel adequately supported following Mr Page's death.

Recommendations

- The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including that they:
  - assess the level of risk based on all available information and known risk factors and not on a prisoner's presentation, and record the reasons for the decision;
  - set appropriate observations according to level of risk and ensure that checks are irregular to prevent the prisoner anticipating when they will occur;
  - ensure agreed actions are recorded on the caremap and the ACCT is not closed until all caremap actions have been fully completed;
  - complete the relevant paperwork, fully and accurately, at all stages of the ACCT process.

- The Governor and Head of Healthcare should review the emergency response procedures**,** ensuring that staff are aware of the mandatory requirements set out in PSI 03/2013, and addressing:
  - the role of the appointed medical responder in responding to a medical emergency and, in particular, the equipment they should take with them when responding;
  - the induction and ongoing training programme for healthcare staff, especially those expected to take on the role of appointed medical responder;
  - the provision of radios to all staff at all times.

- The Governor should ensure that, in accordance with PSI 64/2011, a manager holds a hot debrief promptly after a death in custody and that all those involved in the incident are invited to attend.

The Investigation Process

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

12. The investigator obtained copies of relevant extracts from Mr Page's prison and medical records.

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

14. The investigator and clinical reviewer jointly interviewed five members of staff at HMP Durham. The investigator interviewed one member of staff by telephone. The clinical reviewer interviewed two members of healthcare staff by telephone. The interviews took place between October and December 2017.

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

16. One of the Ombudsman's family liaison officers contacted Mr Page's mother to explain the investigation and to ask if the family had any matters they wanted the investigation to consider. Mr Page's mother did not raise any issues.

17. Mr Page's family received a copy of the initial report. They did not raise any concerns regarding factual accuracy of this report.

Background Information

HMP Durham

18. HMP Durham, which holds up to 996 men, is a local prison serving the courts of Durham, Tyneside and Cumbria. Care UK provides primary healthcare services and Tees, Esk and Wear Valley NHS Trust provides mental health services.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Durham was in October 2016. Inspectors reported that they were not confident that the risks and vulnerabilities of newly arrived prisoners were properly identified and they considered first night processes were of a poor quality. They found that ACCT assessment had improved since the last inspection and prisoners said that the care they received from staff was good. Inspectors found that while care plans were multidisciplinary, the post-closure ACCT reports were sometimes late. Inspectors considered that the quality of healthcare for prisoners with mental ill health was much better than they usually see and there was effective care planning for prisoners with severe and enduring mental health issues.

Independent Monitoring Board

20. 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 annual report for the year to 31 October 2016, the IMB reported that healthcare services were disrupted by staff shortages and sickness. The IMB said that mental health care continued to be good and that wing staff were trained in mental health awareness. They noted their concerns that the prison was overcrowded and operated close to its operational capacity, with cells built for single occupancy nearly all occupied by two prisoners. The IMB reported that the number of prisoners monitored under suicide and self-harm prevention procedures between 2015 and 2016 had increased significantly, which they suggested was due to good practice and awareness.

Previous deaths at HMP Durham

21. Mr Page was the third prisoner to take his life at Durham since January 2016. Previous investigations identified concerns about ACCT monitoring and mental health services.

Assessment, Care in Custody and Teamwork (ACCT)

22. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multidisciplinary review meetings involving the prisoner. As part of the process, a caremap (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed. All decisions made as part of the ACCT process

and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

23. Mr Scott Page was remanded to prison on 12 August 2017 for allegedly breaching his Sex Offender Prevention Order (SOPO) on 27 August 2016 as well as alleged possession of cannabis and amphetamines. He arrived at HMP Durham with a Person Escort Record (PER - which accompanies prisoners on all journeys between police stations, courts and prisons, to communicate risk factors) stating that he was a sex offender and he had asthma. No other risk factors were recorded.

24. Mr Page had a healthcare assessment on reception and the nurse recorded no concerns about Mr Page's physical or mental health. Mr Page said that he had no thoughts of suicide or self-harm. Mr Page also saw the prison GP as part of his healthcare assessment who recorded no concerns.

25. Mr Page was placed on the Vulnerable Prisoners' Unit on F-wing. He attended a brief induction session with a Prisoner Information Desk (PID) worker. The PID worker said that Mr Page seemed very upbeat and he was helping other newly-arrived prisoners as he said he had been a PID worker during previous sentences.

26. Mr Page's cellmate said that he spoke to Mr Page when he joined him in his cell on the afternoon of 12 August. His cellmate said that Mr Page seemed a bit on edge as they spoke to each other about their offences. He said that Mr Page started to take a razor apart and told him that he wanted to take his life because he did not want to cause his family any more heartache and pain. He said that Mr Page spoke about cutting his arms and suffocating himself so that he could not be resuscitated. His cellmate was concerned, so he pressed his cell bell to alert staff.

27. An officer responded to the cell bell and spoke to Mr Page through the cell door. Mr Page told him he did not want to hurt his family or cause them any embarrassment. He said he did not want to put his family through another court case and he felt the only way he could prevent this was to end his life. The officer said he did not see a razor and Mr Page did not tell him how he intended to end his life. The officer started ACCT monitoring and completed the Concern and Keep Safe Form at 6.15pm.

28. Staff monitored Mr Page hourly throughout the night. The ACCT ongoing observations record shows regular observations at exactly 15 minutes past each hour between 8.15pm on 12 August through to 8.15am on 13 August. Observations were then recorded at exactly 30 minutes past each hour between 9.30am and 2.30pm on 13 August.

29. On 13 August at 9.25am, an officer carried out an ACCT assessment interview with Mr Page. Mr Page told the officer that he had let his family down but he did not want to do anything to hurt them. He said he was feeling low when he came into custody the day before, but he now had no thoughts of suicide or self-harm. Mr Page was interested in getting a job as a cleaner and the officer said that he could arrange this for him. The officer said that he had no concerns about Mr Page's risk of self-harm during the assessment interview.

30. On 13 August at 2.40pm, a supervising officer (SO) chaired Mr Page's first ACCT review. An officer also attended this review as well as two mental health nurses. Mr Page repeated what he had said earlier to the officer and said that he had no intention of harming himself. Those present assessed Mr Page's risk of harm as low and agreed to stop ACCT monitoring. Although it had previously been identified that Mr Page was interested in getting a cleaning job, this was not recorded in the ACCT documentation and no actions were added to the caremap. A post-closure review was set for 20 August.

31. On the afternoon of 14 August, the PID worker saw Mr Page for a more in-depth induction onto F-wing. The PID worker said that he had no concerns about Mr Page and that he seemed upbeat and cheerful. Mr Page thanked him and shook his hand at the end of the induction session. CCTV shows Mr Page returning to his cell at approximately 2.30pm.

32. At approximately 4.15pm, Mr Page's cellmate returned from work and, on looking through the cell's observation panel, he saw Mr Page hanging from the end of the bunk bed. He shouted for assistance and an officer and SO attended immediately. On entering the cell, they saw Mr Page had used a sheet as a ligature and had placed a pillowcase and a plastic bag on his head. The SO lifted Mr Page's body while the officer cut the ligature before removing the pillowcase and bag from his head and lying him on the floor. The SO radioed a code blue (a medical emergency code which tells the control room that a prisoner is unresponsive and an ambulance is required).

33. Another officer had arrived at the cell by this time and he began CPR immediately while waiting for healthcare assistance to arrive. Nurse A, who had been administering medication on a lower landing and was not carrying a radio, was alerted by a prison officer. She attended and took over CPR. Nurse B, the appointed medical responder, arrived at the cell at 4.20pm with no equipment. Nurse A asked Nurse B to get a defibrillator (a machine that monitors heart rhythm and delivers an electric shock if an appropriate rhythm is detected). An officer gave Nurse B the defibrillator, which is usually kept in the wing office, and Nurse B left the cell briefly to get an emergency medical bag and oxygen. Nurse A continued CPR with the assistance of a prison manager. When Nurse B returned, she and Nurse A continued with CPR until paramedics arrived at 4.38pm. Nurse A described the space in the cell as being very tight and said that, at one point, another member of staff accidentally kicked her in her face while trying to assist Mr Page. When the paramedics arrived, they immediately moved Mr Page into the corridor and continued with the resuscitation attempt. This was unsuccessful and Mr Page was pronounced dead at approximately 5.05pm.

34. Mr Page left a number of notes in his cell in which he made clear that it was his intention to take his own life and to make others believe otherwise. He said that he was an actor and he had "played the role of a prisoner who was coping again". He specifically asked that no staff members were blamed for his death as everyone had treated him with compassion and professionalism. He apologised to family and friends for letting them down and asked for forgiveness.

Contact with Mr Page's family

35. Mr Page's mother was listed as his next of kin. Two officers visited her at her house on 14 August at approximately 6.45pm to inform her of her son's death. The prison contributed to the cost of Mr Page's funeral, in line with Prison Service instructions.

Support for prisoners and staff

36. All staff involved in the emergency response should have attended a debrief led by a senior manager, but this did not take place. Some staff said that they were offered support by the prison's care team.

37. The Governor posted a notice for prisoners informing them of Mr Page's death and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Page's death.

Post-mortem report

38. The pathologist found that Mr Page's death was due to hanging. The toxicology report showed no evidence of the presence of alcohol or illicit drugs.

Findings

Identifying and managing risk of suicide or self-harm

39. Mr Page's cellmate said that Mr Page had spoken openly about taking his own life, and given graphic details of how he intended to do this. He said that Mr Page was dismantling a razor and said that he was going to cut his wrists and suffocate himself so that he could not be resuscitated. He said that, when he alerted an officer to what Mr Page had been saying, Mr Page then told the officer the same thing. However, the officer said that Mr Page told him he was having thoughts of taking his life but he did not tell him any details of what he intended to do. He also said he did not see Mr Page with a razor and, if he had, he would have taken it from him as he believed he was at risk of suicide or self-harm.

40. Other members of staff involved in the ACCT process said that they would have considered monitoring Mr Page for longer if they had known he had made a clear statement of intent to take his life, as described by his cellmate. In the event, from the information available to them as well as Mr Page's presentation, staff assessed his risk as low and stopped ACCT monitoring after only one day.

41. We consider that the officer was sufficiently concerned to start ACCT monitoring after speaking to Mr Page at his cell door, so we can find no reason why he would not have provided full details, as he understood them, when completing the Concern and Keep Safe form. We therefore found that, while it is likely that Mr Page may have given a clear statement of intent to take his life when speaking to his cellmate, he did not do so when he spoke to the officer. On balance, we consider that the officer provided as much information as he had available to him when he started ACCT monitoring. We do not consider that staff could have known that Mr Page was at imminent risk of suicide at the time he died and we acknowledge that he was convincing in his denial of self-harm, a fact that he himself acknowledged in the notes he left in his cell.

42. Although we found that staff identified and managed Mr Page's risk satisfactorily and that it is unlikely his death could have been prevented, we found some weaknesses in the ACCT procedures.

43. Firstly, when Mr Page was being monitored on an hourly basis, the timings of each observation were predictable to the extent that, if he had intended to take his life at that time, he could easily have timed it so as to avoid discovery for up to an hour.

44. Secondly, there was an agreed action at the first ACCT review that Mr Page would be considered for employment, yet no caremap was completed to record this. The SO and officer said that they did not think a caremap was necessary because, although Mr Page had not started work, a cleaning job was already lined up for him and therefore the action was completed. However, ACCT procedures require that any identified action should be recorded on a caremap and the ACCT should not be closed until all caremap actions have been completed.

45. Finally, the completion of the ACCT review documentation was inaccurate as there was no mention that one of the nurses who attended was present and the other nurse's name was incorrectly recorded.

46. We do not consider that these deficiencies affected the outcome for Mr Page but, if not addressed, they could impact on the outcome for other prisoners at risk of suicide and self-harm in the future. We therefore 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 that they:

- **assess the level of risk based on all available information and known risk factors and not on a prisoner's presentation, and record the reasons for the decision;**
- **set appropriate observations according to level of risk and ensure that checks are irregular to prevent the prisoner anticipating when they will occur;**
- **ensure agreed actions are recorded on the caremap and the ACCT is not closed until all caremap actions have been fully completed;**
- **complete the relevant paperwork, fully and accurately, at all stages of the ACCT process.**

Emergency response

47. Nurse A was the first member of healthcare staff to attend Mr Page's cell. However, she had not heard the code blue call because she was not carrying a radio and attended only because a prison officer had alerted her that healthcare assistance was required. Nurse A took charge of the situation on arrival and took over CPR from an officer.

48. Nurse B was the appointed medical responder and she arrived shortly afterwards, having heard the code blue, but did not bring an emergency bag or oxygen with her. Nurse A had to ask Nurse B to get a defibrillator. Nurse B, who started working at the prison in January 2017, told the clinical reviewer that she was not aware of any specific protocol for responding to an emergency as the appointed medical responder and was unaware of the need to collect the emergency bag on the way to the incident. We are satisfied that Durham's Governor's Order 08.15 sets out the mandatory requirement for the appointed medical responder to respond with the necessary equipment, in accordance with the Prison Service Instruction (PSI) on Medical Emergency Response Codes, PSI 03/2013. Therefore, we conclude that Nurse B's induction into the role was not as robust as it should have been.

49. We are satisfied that staff responded quickly to the emergency and that the short delay in getting the relevant medical equipment to Mr Page's cell was unlikely to have affected the outcome. Nevertheless, it is important that any delays in administering emergency life support are minimised by ensuring that healthcare staff responding to a medical emergency code take the appropriate emergency medical equipment with them.

50. We also consider that all healthcare staff should carry a radio at all times so that they are aware if a medical emergency code is called.

51. In addition, we consider that prison and healthcare staff should have considered moving Mr Page out of his cell onto the landing earlier. This would have resulted in a more orderly attempt at resuscitation, without the risk of injury to staff. We make the following recommendation:

The Governor and Head of Healthcare should review the emergency response procedures, ensuring that staff are aware of the mandatory requirements set out in PSI 03/2013 and addressing:

- **the role of the appointed medical responder in responding to a medical emergency and, in particular, the equipment they should take with them when responding;**
- **the induction and ongoing training programme for healthcare staff, especially those expected to take on the role of appointed medical responder;**
- **the provision of radios to all staff at all times.**

Support for staff

52. While the majority of staff said they felt supported by colleagues, managers and the prison's care team following the death of Mr Page, we found no evidence that all those involved in the incident were appropriately debriefed. Safer Custody PSI 64/2011 states, "*In line with PSI 08/2010 Post Incident Care, a 'Hot Debrief' must be held immediately after all deaths in custody. A senior member of staff must act as the debriefer and a member of the care team must attend. All staff directly involved in the incident, including healthcare staff, should be invited. It may be useful to keep a record of those who attend*". Nurse B said she did not recall being invited to attend a debrief and Nurse A said she did not receive any formal support after the incident. The duty governor provided a contemporaneous note of discussions held with some individual members of staff following Mr Page's death. This note stated that a hot debrief had not been possible at the time due to operational reasons. We therefore make the following recommendation:

The Governor should ensure that, in accordance with PSI 64/2011, a manager holds a hot debrief promptly after a death in custody and that all those involved in the incident are invited to attend.

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