Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Raymond Mulligan a prisoner at HMP Durham on 29 March 2018

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.

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

Mr Raymond Mulligan died on 28 March 2018, when he was found hanged in his cell in HMP Durham. He was 44 years old. I offer my condolences to Mr Mulligan's family and friends.

Mr Mulligan had been released on licence and was recalled to prison five days before he died. He had a history of depression, self-harm and alcohol abuse. He arrived in Durham with a self-harm warning form, and reception staff put him on Prison Service measures designed to support prisoners at risk of self-harm.

I am concerned that, although Mr Mulligan had a wide range of risk factors for suicide and self-harm, he was assessed as posing a low risk to himself, and that staff seem to have relied too much on Mr Mulligan's assertions that he did not intend to kill himself rather than balancing this against all his risk factors,

I am also concerned that the officer who found him did not use the appropriate emergency code. Although it would not have saved Mr Mulligan, this could make a difference in other cases.

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

Sue McAllister, CB
Prisons and Probation Ombudsman **February 2019**

Contents

Summary

Events

1. Mr Mulligan had a history of anxiety and depression, including attempts to take his own life. He was released from prison on licence in 2017. On 17 March 2018, following concerns about his increased use of alcohol and the breakdown of his relationship with his partner, he was admitted to hospital after taking an overdose of prescribed medication. On 22 March, he was convicted of further offences. His licence was revoked and he was recalled to prison.

2. He arrived at HMP Durham on 23 March with a warning form recording that he had expressed thoughts of suicide. Along with his history, this caused staff to open ACCT monitoring procedures, the Prison Service's support process for those at risk of self-harm. His risk to himself was assessed as low. At his reception health screening he was referred for a mental health assessment.

3. On 25 March, Mr Mulligan told a healthcare support worker that he was having thoughts of harming himself. An officer told him he could ask for support from Listeners (prisoners trained by the Samaritans) if he needed it.

4. Staff checked him in line with his ACCT guidelines, and healthcare staff monitored his alcohol withdrawal. Throughout the week he was judged to continue to need ACCT support but staff did not consider he was at imminent risk of suicide or self-harm.

5. On the afternoon of 27 March, Mr Mulligan played pool with other prisoners, collected his meal, and went back to the cell he was sharing with another prisoner. They talked and watched television through the evening. His cellmate did not see any reason to be concerned about Mr Mulligan. Prison staff checked on him through the night and there were no apparent problems.

6. Shortly before 5.00am on 28 March, the night officer went to check Mr Mulligan and found him hanging. The officer called for assistance and he and a colleague went into the cell. They cut down Mr Mulligan's body, at which point a nurse joined them. She and another nurse assessed Mr Mulligan, but it was clear that he had died and it was not appropriate to attempt resuscitation.

Findings

Risk assessment

7. Mr Mulligan arrived at Durham with a suicide and self-harm warning form. Staff noted and acted upon this and appropriately opened ACCT procedures in reception. Following his reception health screening he was referred for a mental health assessment.

8. We are concerned, however, that Mr Mulligan's risk of suicide and self-harm was assessed as 'low' at this point, given the number and range of risk factors he had, including his very recent overdose, his expressed suicidal thoughts, his recent relationship breakdown, that he was withdrawing from alcohol at the time, and the fact that staff had not had time to get to know him.

9. We are also concerned that when Mr Mulligan told a healthcare support worker that he was having thoughts of harming himself two days after the ACCT was opened, but this did not trigger a review of his risk.

10. In the three days before he died, Mr Mulligan gave no indication that he was at imminent risk of taking his own life. However, we are concerned that staff seem to have relied too much on Mr Mulligan's assertions that he did not intend to kill himself rather than balancing this against all his risk factors, including his diagnosis of depression, his previous and recent history of self-harm, the breakdown of his relationship and the fact that he was only a few days into his recall.

Healthcare

11. The clinical reviewer noted that Mr Mulligan was seen daily by the drug and alcohol team to monitor his withdrawal from alcohol. He received a mental health assessment and was referred to mental health services. The clinical reviewer considered that Mr Mulligan received appropriate healthcare in Durham.

Emergency response

12. When a prison officer found Mr Mulligan hanging he did not use an emergency code. This delayed the calling of an ambulance and meant that the nurse who attended did not bring the emergency bag. On this occasion it was clear that Mr Mulligan had already died, and the delay did not affect the outcome. It could, however, affect the outcome for other prisoners in the future.

Recommendations

- The Governor and Head of Healthcare should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including that staff:
    - staff consider and record all the known risk factors of newly arrived prisoners when determining their risk of suicide or self-harm;
    - set effective caremap actions that are specific and meaningful, aimed at reducing risk, and update them at each case review;
    - and record all significant conversations or events in ACCT documents.

- The Governor should remind staff of the importance of using the correct codes in an emergency, and the potential consequences of not doing so.

The Investigation Process

13. 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.

14. The investigator visited Durham in May 2018 and obtained copies of relevant extracts from Mr Mulligan's prison and medical records. He interviewed three members of staff and one prisoner at Durham.

15. NHS England commissioned a clinical reviewer to review Mr Mulligan's clinical care at the prison. He joined the investigator for interviews of healthcare staff.

16. We informed HM Coroner for Durham and South Darlington of the investigation. He gave us the results of the post-mortem examination and we have sent the coroner a copy of this report.

17. One of the Ombudsman's family liaison officers contacted Mr Mulligan's brother, to explain the investigation and to ask whether he had any matters the family wanted the investigation to consider. Mr Mulligan's brother asked about mental health care and risk assessment. He also said that the prison had only given him minimal information about what had happened.

18. Mr Mulligan's brother received a copy of the initial report. He did not raise any further issues.

Background Information

HMP Durham

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

HM Inspectorate of Prisons

20. The most recent inspection of HMP Durham was conducted in October 2016. Inspectors reported that Assessment, Care in Custody and Teamwork (ACCT) assessment had improved since their last inspection and prisoners said the care they received from staff was good. Inspectors found that while care plans were multidisciplinary, the post closure ACCT reviews were sometimes late. Inspectors considered that the quality of healthcare for prisoners with mental ill health was much better than they would usually see and there was effective care planning for prisoners with severe and enduring mental health issues.

Independent Monitoring Board

21. 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 2017, the IMB reported that a case manager is allocated to every ACCT that is opened, and has responsibility for the case until it is closed. The IMB said the prison held effective ACCT reviews which were audited for quality. The Board noted that mental healthcare is well integrated and waiting times and delays are monitored and addressed.

Previous deaths at HMP Durham

22. Mr Mulligan was the eighteenth prisoner to die at Durham since February 2015. Of these earlier deaths, seven had taken their own lives, one appears to have been drug related, and nine were due to natural causes. We have previously criticised the failure of reception staff to identify prisoners' risk factors and properly assess the risk of suicide and self-harm, and identified concerns about ACCT monitoring. In a recent report, we raised concerns about the use of appropriate emergency codes. Since Mr Mulligan's death, one prisoner has taken his own life, there have been two drug related deaths, two prisoners have died from natural causes, and a further two are awaiting classification.

Assessment, Care in Custody and Teamwork

23. 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. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner.

24. 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, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody).*

Key Events

25. Mr Mulligan was serving a prison sentence of four years and six months. He had a history of anxiety and depression and had made a number of attempts at suicide, both in the community and in custody. These attempts had included overdosing on prescription drugs and attempting to hang himself while in a probation hostel. He had previously been supported under Prison Service procedures to support those at risk of self-harm (known as Assessment, Care in Custody and Teamwork, or ACCT).

26. Sentenced in 2015, he had been released on licence in May 2017. Following an increased use of alcohol and a breakdown in his relationship with his partner, he was admitted to hospital on 17 March 2018 after an overdose of prescribed medication. On 22 March he was convicted of further offences. His licence was revoked and he was recalled to prison. He arrived at HMP Durham on 23 March.

27. Among the papers that accompanied Mr Mulligan to prison was a self-harm warning form, which showed that he had expressed thoughts of suicide. Because of the self-harm warning form, Mr Mulligan's history of self-harm, his low mood and because he was withdrawing from alcohol use, a Supervising Officer (SO) opened ACCT monitoring procedures. Staff were to check on him every hour.

28. A nurse gave Mr Mulligan a reception health screen. He noted Mr Mulligan's heavy alcohol use, his recent overdose, and his history of anxiety and depression. The medical record showed that Mr Mulligan would need observation for symptoms of alcohol withdrawal that night. He was prescribed chlordiazepoxide and thiamine (for alcohol withdrawal).

29. Mr Mulligan was allocated a cell in the first night centre on E wing. He signed the wing's compacts, and an officer issued him with a vape pack. He told the officer that he had no thoughts of self-harm or suicide.

30. A nurse saw Mr Mulligan in his cell that evening. He said he had no concerns, and she did not notice any signs of alcohol withdrawal. She checked him on further occasions during the night and again saw nothing to cause concern. Wing staff also checked on Mr Mulligan through the night in line with his ACCT monitoring.

31. On the morning of 24 March, an officer conducted an ACCT assessment interview. Mr Mulligan said he was upset that his former partner had accused him of the crimes of which he had been convicted. He said that he suffered from anxiety and depression but was not currently on any medication. Twice in the previous week he had taken overdoses of paracetamol with alcohol, and said that if he had known he was going to be taken back to prison he would have jumped off a bridge. He told her that he had tried to overdose many times in the past, and had tied a ligature round his neck, as well as cutting his legs and arms. He had been in contact with the Crisis team three days before he arrived in Durham, and they had taken him to hospital.

32. The officer noted on the ACCT form that Mr Mulligan was upset and appeared very down. He said that every day he felt that he wanted to die, he couldn't

change the way he felt, and thought about ways he could take his own life. He said that he had family support and close friends, which were reasons for living. He and the officer discussed the possibility of moving cells so he could use the telephone, as the one in his cell was not working. He also wanted to get a job as he did not like being idle. He also wanted to engage with the mental health team. She summarised that Mr Mulligan should work with the drug and alcohol team to help his alcohol withdrawal, he should start work or education as soon as possible, he should see the doctor about his medication, and should engage with the mental health team.

33. At 11.00am the unit manager, chaired a review of Mr Mulligan's ACCT. Mr Mulligan attended, along with the officer who conducted the ACCT assessment interview and a nurse. Mr Mulligan said that he was struggling with alcohol withdrawal, but was prepared to work with the drug and alcohol team and had begun a course of detoxification. He wanted a job to fill his time. He said that he was still having suicidal thoughts, but that this was normal and he had protective factors that prevented him from acting on them. The note of the meeting showed that his risk was assessed as being low, but he was to remain under ACCT management until he had a job and had an appointment to see the doctor. The caremap said that he should see a doctor about his depression, and noted that the nurse would arrange this. Mr Mulligan agreed to speak to staff if he had any concerns. Observations were set at one conversation each morning, afternoon and evening, with three checks during the night.

34. Mr Mulligan's ACCT document shows that through the rest of the day he was out of his cell to collect his lunch, he went out for association, and he collected his dinner. He saw a chaplain as part of his induction. There were no apparent problems. The nurse checked him again that evening, with no concerns noted. Staff checked on him during the night in accordance with his ACCT observations.

35. On 25 March, at 9.20am a healthcare support worker, saw Mr Mulligan as part of his detoxification programme. Mr Mulligan said that he was having thoughts of harming himself. She passed this on to a wing officer who told Mr Mulligan to alert a member of staff if he needed to speak to a chaplain or a Listener. (These are prisoners trained by the Samaritans to provide peer support.)

36. Staff conducted ACCT checks on Mr Mulligan five times during 25 March and there were no apparent problems. After prisoners were locked into their cells for the night he was noted to be talking to his cellmate. At 7.40pm, an officer spoke to Mr Mulligan and he did not raise any concerns. Staff checked on him three times during the night as directed.

37. On 26 March, at 10.00am, Mr Mulligan saw a member of the drug and alcohol team for induction. He engaged well, said he had no thoughts of harming himself, and raised no concerns. At 10.30am a member of the chaplaincy team spoke to Mr Mulligan. He said that he did not want to talk at that moment but would like to another time.

38. During the night, staff conducted ACCT checks on Mr Mulligan three times as directed. There was nothing that caused them concern.

39. On 27 March, at 9.00am, Mr Mulligan said that he did not want to get up for his medication. He later did so but also told an officer that he did not want to be under ACCT management. When he was out of his cell for association that afternoon, he asked the officer if he would be able to get a job.

40. Mr Mulligan's ACCT document recorded that at 6.30pm, he asked a member of staff (the name is illegible) about his medication, and said that he felt that he needed to work. The member of staff noted that they told him that they would speak to the wing manager about a job, and would arrange for Mr Mulligan to see a member of the healthcare team the following day.

41. Staff checked Mr Mulligan during the night as directed by his ACCT document. There were no reasons for concern.

42. On Wednesday 28 March, staff made observation checks on Mr Mulligan through the day. His electronic record shows that at 11.33am he declined to engage with someone from the Northumbria Community Rehabilitation Company but there were no apparent problems.

43. A healthcare support worker, assessed Mr Mulligan for alcohol withdrawal that afternoon. He said that his fluid intake was not good but he was trying to drink and was taking his medication. He said he had no particular issues to raise. She encouraged him to report any changes or concerns, but he said that he had none at that time.

44. Mr Mulligan came out of his cell for association at 3.00pm and played pool with other prisoners. At 5.00pm he collected his evening meal, had his medication, and went back to his cell, where he had a new cellmate. The cellmate said that they chatted, shared an electronic cigarette and watched television. When checked at 7.00pm Mr Mulligan was watching television and told the prison officer that he was fine. At 9.00pm an officer checked on Mr Mulligan who was still watching television. He told the officer that he was fine. At 10.30pm a nurse gave the cellmate his medication, and there were no problems raised.

45. The cellmate said that when he was being given his medication, he saw a photograph of a woman on the cell noticeboard, with a drawing of a broken heart next to it. He said he and Mr Mulligan then went to sleep. He said that he woke at about 2.00am and noticed that the writing on the noticeboard had changed. He could not, however, see what it said, and went back to sleep. (CCTV evidence subsequently showed that it said that Mr Mulligan felt that his partner had driven him to suicide, with a drawing of a sad face and a broken heart.)

46. On 29 March, at 2.30am, an officer checked on Mr Mulligan. CCTV footage shows him shining his torch through the observation panel. The officer noted that Mr Mulligan was asleep in his bed, and that he noted movement.

47. At 4.53am, the officer went to conduct an ACCT check on Mr Mulligan, and saw him hanging from the upper bunk bed. He used his radio to ask for senior staff and the healthcare emergency responder to attend. He ran across the landing to the nurses' station, and called across the landing to the operational support grade (OSG) to get the emergency response nurse, who was in an office nearby.

48. Officers on night duty do not carry ordinary cell keys but have a key in a sealed pouch for use in emergencies. The officer broke the seal on his pouch and opened the door as the OSG arrived at the cell. CCTV footage shows that this was approximately 50 seconds after the officer first arrived at the door. They went in, cut the ligature and lowered Mr Mulligan to the floor.

49. At this point a nurse arrived. She assessed Mr Mulligan but could find no signs of life. She arrived and checked Mr Mulligan. The nurses agreed that he was clearly dead and it would be inappropriate to attempt resuscitation.

50. At 5.05am, the manager in charge of the prison that night, telephoned the control room and asked them to call an ambulance. They requested an ambulance at 5.07am. Paramedics arrived at the prison at 5.12am, at the cell at 5.15am, and pronounced Mr Mulligan had dead.

Contact with Mr Mulligan's family

51. An officer was appointed family liaison officer (FLO). Mr Mulligan's brother was his next of kin, and the FLO and a colleague went to inform him of his brother's death.

52. In line with Prison Service policy, Durham offered a contribution towards the costs of Mr Mulligan's funeral.

Support for prisoners and staff

53. After Mr Mulligan's death, one of the prison's managers, debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

54. Prisoners were notified of Mr Mulligan's death by notices posted on the wings, which indicated where they could get support if they felt it necessary. All prisoners subject to ACCT monitoring had their circumstances reviewed in case they had been affected by Mr Mulligan's death. This included the cellmate who was under the care of the mental health team.

Post-mortem report

55. The post-mortem report showed that Mr Mulligan died as a result of hanging. Toxicology tests showed only therapeutic levels of medication.

Findings

Risk assessment

56. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others* (Safer Custody), and PSI 7/2015, *Early Days in Custody – Reception in, first night in custody, and induction to custody*, both list a number of risk factors and potential triggers for suicide and self-harm. Mr Mulligan had a number of these risk factors, including a history of depression, a history of self-harm including a recent overdose, heavy alcohol use, being charged with an offence of violence against a family member, the breakdown of his relationship with his partner, and being in the early days of custody after being recalled.

57. Mr Mulligan arrived at Durham with a self-harm and suicide warning form. Prison staff noted and acted on this appropriately by opening ACCT procedures in reception. However, we question whether it was appropriate to have assessed Mr Mulligan's risk to himself as 'low' at this point given the number and range of risk factors he had, including his very recent overdose, his expressed suicidal thoughts, his recent relationship breakdown, that he was withdrawing from alcohol at the time, and the fact that staff had not had time to get to know him.

58. The caremap appropriately identified that he needed to see a doctor about his depression and to be found employment to keep him occupied during the day. He was also referred for a mental health assessment and was appropriately treated and monitored for alcohol withdrawal. However, we are concerned that Mr Mulligan's distress about his relationship breakdown does not seem to have been recognised as a key risk factor.

59. Two days after the ACCT was opened, Mr Mulligan told a healthcare support worker that he was having thoughts of harming himself. This could also have been an opportunity to explore what was causing Mr Mulligan to feel this way and what might be done to support him.

60. Over the next three days, Mr Mulligan told staff that he had no thoughts of suicide or self-harm, although he continued to ask about getting a job to keep him occupied and wanted to see healthcare staff about his medication. His new cellmate also had no concerns about him (although he did not know Mr Mulligan well as he had only moved in to the cell at 5.00pm the evening before Mr Mulligan's death).

61. We accept that Mr Mulligan gave staff no indication that he was at imminent risk of taking his life in the days before he died. We also recognise that assessing the risk a prisoner poses to himself is not an exact science. However, it should involve balancing the prisoner's demeanour and behaviour against known risk factors. Staff need to develop as comprehensive an understanding as possible of the risk factors. In this case, we are concerned that staff seem to have relied too much on Mr Mulligan's assertions that he did not intend to kill himself rather than balancing this against all his risk factors, including his diagnosis of depression, his previous history of self-harm, the breakdown of his relationship and the fact that he was only a few days into his recall.

62. We make the following recommendation:

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

- **consider and record all the known risk factors of newly arrived prisoners when determining their risk of suicide or self-harm;**
- **set effective caremap actions that are specific and meaningful, aimed at reducing risk, and update them at each case review; and**
- **record all significant conversations or events in ACCT documents.**

Healthcare

Substance misuse

63. The clinical reviewer noted that Mr Mulligan was seen on a daily basis by the drug and alcohol team to monitor his withdrawal from alcohol. He did not display any overt withdrawal symptoms. The clinical reviewer had no concerns about this aspect of Mr Mulligan's care.

Mental healthcare

64. On arrival in Durham, Mr Mulligan was referred for a mental health assessment. Community Psychiatric Nurse (CPN) carried out a mental health assessment during the ACCT review the following day, using a template to ensure a full assessment was made. Mr Mulligan disclosed his history of mental health problems and recent self-harm. The CPN referred him to the primary care mental health service. The Clinical Reviewer considers that Mr Mulligan was appropriately assessed by the mental health services.

65. The clinical reviewer concluded that Mr Mulligan's overall healthcare was at least equivalent to that which he could have expected in the community. He made no recommendations.

Emergency response

66. Prison Service Instruction 03/2013 requires governors to have a two code medical emergency response system based on the instruction. As is usual, Durham use code blue to indicate an emergency when a prisoner is unconscious, or having breathing difficulties, and code red when a prisoner is bleeding. Calling an emergency code should automatically trigger the control room to call an ambulance.

67. When the officer found Mr Mulligan hanging, he called for senior staff and healthcare staff, but did not call a code blue emergency. This meant that the nurse did not bring the emergency bag with her to the cell, and that the control room did not immediately request an emergency ambulance. An ambulance was not summoned until a manager asked for one. Between the officer finding Mr

Mulligan and the control room requesting an ambulance there was a delay of approximately 14 minutes.

68. In his statement, the officer accepted that he had not used called a code blue emergency, despite knowing the procedure. He said that it was the first time that he had found himself in this situation and he was in a degree of shock. In this instance, it is fairly clear that Mr Mulligan had already been dead for some time when the officer found him, and the delay did not affect the outcome. In emergencies, however, seconds can be vital and in another situation, such a delay could have serious consequences. We make the following recommendation:

The Governor should remind staff of the importance of using the correct codes in an emergency, and the potential consequences of not doing so.

Family liaison

69. Mr Mulligan's brother initially said that he had been disappointed with the lack of information provided by the prison. The prison's family liaison log showed that more information was subsequently provided to Mr Mulligan's family as details became clearer and contact with the Coroner's office was established.

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