

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Joshua Scholick a prisoner at HMP Durham on 29 September 2018

**A report by the Prisons and Probation Ombudsman**

## 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*



© Crown copyright 2019

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit [nationalarchives.gov.uk/doc/open-government-licence/version/3](http://nationalarchives.gov.uk/doc/open-government-licence/version/3) or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: [psi@nationalarchives.gsi.gov.uk](mailto:psi@nationalarchives.gsi.gov.uk).

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

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.

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

Mr Joshua Scholick died of a heart attack in his cell at HMP Durham on 29 September 2018. He was 26 years old. I offer my condolences to Mr Scholick's family and friends.

Mr Scholick had a significant history of illicit drug use. He refused advice and support from the prison's substance misuse team and continued to use illicit substances in prison. Post-mortem toxicology tests found that Mr Scholick had used a psychoactive substance and illicitly obtained prescription medication before his death, and it is possible that this combination of drugs contributed to his death.

Mr Scholick had been monitored under Prison Service suicide and self-harm monitoring procedures (known as ACCT) for about a week in July and again in September 2018. However, the investigation found no evidence that Mr Scholick's death was a suicide.

Mr Scholick's death was the sixth drug-related death at Durham in 2018. I am concerned that Mr Scholick was able to obtain both illicit drugs and illicit prescription medication at Durham with apparent ease. The prison clearly needs to do more to prevent the supply of and demand for illicit substances.

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**

**August 2019**

## **Contents**

Summary .....	1
The Investigation Process .....	3
Background Information .....	4
Key Events .....	6
Findings.....	11

# Summary

## Events

1. Mr Joshua Scholick had a significant history of illicit drug use, and had been diagnosed with a personality disorder and psychosis. He had been in prison before. On 14 May 2018, Mr Scholick appeared in court charged with affray and was remanded into custody at HMP Durham.
2. On 13 July, Mr Scholick made a ligature and staff immediately began monitoring him under Prison Service suicide and self-harm prevention procedures (known as ACCT). The ACCT was closed on 18 July, when staff assessed that Mr Scholick's mood had improved.
3. On 24 July, staff searched Mr Scholick's cell in response to intelligence that he was involved in the use of drugs. Staff found a supply of illicit drugs and illicit prescription medication.
4. On 17 September, following further intelligence, staff searched Mr Scholick's cell and found two mobile phones and a charger.
5. On 18 September, Mr Scholick self-harmed and staff immediately began monitoring him under suicide and self-harm prevention procedures. The ACCT was closed on 24 September, when staff assessed that Mr Scholick's mood had improved. They noted that he was due to appear in court on 19 October.
6. On 29 September, at 9.16am, Mr Scholick's cellmate raised the alarm when he found Mr Scholick unconscious in his bed. Staff requested an ambulance and nurses responded but did not start cardiopulmonary resuscitation as it was clear Mr Scholick was dead. The paramedics arrived at 9.41am and pronounced Mr Scholick dead.

## Findings

### Illicit Substances

7. Mr Scholick died of a heart attack. Toxicology tests showed that, before his death, he had used psychoactive substances (PS) and prescription drugs which had not been prescribed to him, and the pathologist concluded that it is possible this combination of drugs contributed to Mr Scholick's death.
8. Mr Scholick had a history of illicit drug abuse. There was intelligence that Mr Scholick was involved in the use of drugs at Durham. Staff conducted intelligence-led searches of his cell and found illicit drugs, illicit medication and mobile phones. He was offered support and advice from the prison's substance misuse team, but refused to engage with them.
9. Durham has comprehensive policies designed to minimise and treat illicit substance misuse. Despite this, Mr Scholick was able to access PS and drugs that had not been prescribed to him with apparent ease. We are very concerned that Mr Scholick's death was the sixth drug-related death at Durham in 2018 and we are copying this report to the Prison Group Director for Tyne and Wear to assure himself that the prison is taking appropriate action.

## **Management of risk of suicide and self-harm**

10. We found that ACCT procedures at Durham were conducted in line with mandatory national instructions and case reviews were multidisciplinary. Although we consider that the ACCT may have been closed prematurely in September 2018, we found no evidence that Mr Scholick's death was a suicide.

## **Clinical care**

11. The clinical review concluded that the care provided to Mr Scholick was equivalent to that which he could have expected to receive in the community. Mr Scholick was repeatedly assessed by mental health staff who were responsive to his concerns. Mr Scholick refused any intervention from substance misuse services.

## **Recommendations**

- The Governor should ensure that the key drug issues at Durham are identified and that the prison's local drugs strategy is revised to ensure that these key issues are being addressed, including the trafficking and trading of prescription medication.
- The Prison Group Director for Tyne and Wear should satisfy himself that Durham is taking appropriate action to address the supply of and demand for drugs, and should report his conclusions to the Ombudsman.

## The Investigation Process

12. 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.
13. The investigator visited Durham on 8 October. He obtained copies of relevant extracts from Mr Scholick's prison and medical records.
14. NHS England commissioned a clinical reviewer to review Mr Scholick's clinical care at the prison.
15. The investigator interviewed five members of staff and one prisoner at Durham in November, all jointly with the clinical reviewer.
16. We informed HM Coroner for Durham and Darlington of the investigation. He gave us the results of the post-mortem examination and toxicology results. We have sent the coroner a copy of this report.
17. The investigator contacted Mr Scholick's next of kin, his mother, to explain the investigation and to ask whether there were any matters she wanted the investigation to consider. Mr Scholick's mother asked what mental health care her son had received. She also said she believed that Mr Scholick had wanted to move cells because he was being bullied by his cellmate.
18. The investigator was contacted by Mr Scholick's father. The investigator explained the investigation and asked whether there were any matters he wanted the investigation to consider. Mr Scholick's father wanted to know why he had not been contacted by the prison at the time of his son's death.
19. We have addressed these concerns in this report. Both Mr Scholick's mother and father received a copy of the initial report. They did not make any comments.

## Background Information

### HMP Durham

20. HMP Durham is a designated reception prison which holds up to 996 men who are on remand or recall. It serves the courts of Durham, Tyneside and Cumbria. Care UK provides primary healthcare services and Tees, Esk and Wear Valley NHS Trust provide mental health services.

### HM Inspectorate of Prisons

21. HM Inspectorate of Prisons (HMIP) carried out an unannounced inspection of Durham in September/October 2018. Inspectors found that illicit drugs were readily available and that there had been a high number of self-inflicted deaths, and high levels of violence and self-harm. Inspectors found that Durham had developed a drugs strategy but had no modern technology available to stem the flow of drugs into the prison. Inspectors noted that Durham should have received new equipment but that this had been diverted for use in another prison. Inspectors were disappointed to see that recommendations from previous Ombudsman's investigations into deaths had not been addressed with sufficient vigour or urgency.

### Independent Monitoring Board

22. 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, published in March 2019, the IMB commented that the violence which resulted from the trade in illicit drugs, and the use of those drugs, had led to an unstable prison. The IMB noted that Durham was making strenuous efforts to prevent drugs coming into the prison but more advanced technology was needed to tackle the problem.

### Previous deaths at HMP Durham

23. Mr Scholick's was the tenth death to occur at Durham since January 2018. Of these ten deaths, two were from natural causes, two were from hanging and the remaining six were drug-related. In our investigations into previous deaths, we made recommendations about the assessment of prisoners' risk, availability of drugs, and emergency response.

### Psychoactive Substances (PS)

24. Psychoactive substances (formerly known as 'new psychoactive substances' or 'legal highs') are a serious problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

25. In July 2015, we published a Learning Lessons Bulletin about the use of PS (still at that time NPS) and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of PS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.
26. HM Prison and Probation Service (HMPPS) now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements.

### **Assessment, Care in Custody and Teamwork (ACCT)**

27. 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 carried out at irregular intervals to prevent the prisoner anticipating when they will occur. Regular multidisciplinary review meetings involving the prisoner should be held.
28. 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 prisons at risk of harm to self, to others and from others (Safer Custody)*.

## Key Events

29. Mr Joshua Scholick had a custodial history dating back to 2015, and a significant history of illicit drug use. He had been diagnosed with a personality disorder and experienced several episodes of drug-induced psychosis.
30. On 14 May 2018, Mr Scholick appeared at South Durham Magistrates Court charged with affray. He was remanded into custody at HMP Durham until his appearance at Crown Court on 19 October.
31. When Mr Scholick arrived at Durham, he saw a nurse in reception. The nurse recorded that Mr Scholick had suffered from previous episodes of psychosis, had been diagnosed with a personality disorder and was under the care of the community mental health team. He referred Mr Scholick to the prison's mental health team.
32. A nurse prescriber then saw Mr Scholick. She recorded that Mr Scholick tested positive for opiates, cannabinoids and benzodiazepines. Mr Scholick said he sometimes used cannabis to help him sleep but denied using any other drugs. He said he had been given medication while in police custody. Mr Scholick said he was under the care of the community mental health team and denied having any thoughts of suicide or self-harm. She recorded that although there were no concerns with Mr Scholick's physical health, he would be monitored by the substance misuse team. She did not prescribe any medication.
33. Over the next three days, Mr Scholick was closely monitored by the substance misuse team for signs of drug withdrawal. There were no recorded issues or concerns with Mr Scholick's health. Mr Scholick refused to engage with the substance misuse team and had no further involvement with the service.
34. On 21 May, a nurse who, who was a member of the mental health team, saw Mr Scholick for an assessment following the referral made by another nurse. Mr Scholick said he did not want to be assessed and that he did not need help from the mental health team. He recorded that Mr Scholick had refused to be assessed and had been discharged from mental health team care.
35. On 25 May and 8 June, Mr Scholick failed to attend appointments with the brain injury worker about a past injury.
36. On 11 June, Mr Scholick contacted healthcare and cancelled all his healthcare appointments. He said he did not need them and he did not want to miss going to the gym and to work.
37. On 13 July, at 9.45pm, an officer opened an ACCT after Mr Scholick was found to have made a ligature. Mr Scholick said he had "had enough" as his father was in hospital and his girlfriend had ended their relationship. A nurse recorded that she had assessed Mr Scholick who was sitting up and breathing normally. She referred Mr Scholick to be seen by the mental health team.
38. A Custodial Manager (CM) saw Mr Scholick under the ACCT procedures and completed an immediate action plan. She assessed Mr Scholick as being at raised risk of suicide or self-harm. His level of observations was set at four

times an hour throughout the day and night, plus one recorded conversation in the morning and afternoon, evening and night, until the first case review.

39. At 12.15pm, an officer assessed Mr Scholick as part of ACCT procedures. Mr Scholick said his father was in hospital as he had suffered a heart attack. He also said his girlfriend had been unfaithful to him. He said he had made a ligature and put it around his neck but his cellmate had found him. Mr Scholick said he got on well with his cellmate and did not want to be moved.
40. On 14 July, a CM held the first ACCT case review. Also present were a nurse, a member of the mental health team, a Supervising Officer (SO), an officer and Mr Scholick. Mr Scholick said he no longer had any thoughts of self-harm or suicide. He said he made the ligature because he believed his father might have died and because his girlfriend had ended their three-year relationship. Mr Scholick said he had received support from a community mental health nurse before entering prison. He said he enjoyed attending the wood work class and the gym.
41. A CM assessed Mr Scholick as being at low risk of suicide and self-harm. She reduced his level of observations to two recorded conversations in the morning, afternoon and evening, and to five observations during the night.
42. The CM completed the ACCT caremap. This contained two actions: that Mr Scholick would work with the mental health team, and that the chaplaincy would contact his father. The next case review was set for 18 July.
43. On 15 July, a nurse saw Mr Scholick for a mental health assessment. Mr Scholick said that he had attempted to self-harm due to issues with his girlfriend and that his father had suffered a heart attack. He said that he no longer felt suicidal and had no further plans to self-harm. Mr Scholick said that he had a diagnosis of psychosis, post-traumatic stress disorder (PTSD) and had a brain injury. He said he always carried a weapon in the community for his own safety. She recorded that there were no current symptoms of mental illness but she added Mr Scholick to her caseload for ongoing support.
44. On 18 July, a SO chaired an ACCT review with an officer and Mr Scholick present. A nurse from the mental health team contributed to the review by telephone. Mr Scholick said he felt "ok", had no thoughts of harming himself and would speak to staff if necessary. He said he was pleased that his father was better and his girlfriend had booked a visit to see him, so he was hopeful that their relationship would continue. A SO told Mr Scholick that he had an appointment with a nurse on 27 July.
45. The SO assessed that Mr Scholick was at low risk of self-harm and agreed to close the ACCT. He updated the caremap given that the two actions were now completed. A post-closure interview was set for 25 July.
46. On 24 July, Mr Scholick was to be found under the influence of an illicit substance. Staff searched Mr Scholick's cell and found four wraps of illicit drugs and five illicitly obtained pregabalin tablets (a prescription-only drug used for neuropathic pain and epilepsy).

47. On 25 July, an officer held the scheduled ACCT post-closure interview with Mr Scholick. Mr Scholick said he had no thoughts of self-harm, had received support from his girlfriend and would speak to staff if he had any concerns or wanted support.
48. On 27 July, a nurse contacted the community mental health team to obtain information about the care that Mr Scholick had received before he entered prison. They responded that the last recorded intervention with Mr Scholick had been in December 2017, when he had had an appointment with the neuropsychologist.
49. That afternoon, a nurse saw Mr Scholick for a mental health review. She recorded that Mr Scholick quickly became verbally abusive towards her. She told him she would review him again when he was calmer. She also recorded that Mr Scholick showed no evidence of having any psychotic symptoms or thought disorder.
50. On 22 August, a nurse from the mental health team saw Mr Scholick for a mental health review. Mr Scholick said he was low in mood and his head was "all over the place". He said he was due back in court sometime in the week beginning 17 September. Mr Scholick denied having any thoughts of self-harm or suicide. He recorded that although Mr Scholick was low in mood, there was no evidence of any psychosis or thought disorder. He noted that he would continue to support Mr Scholick.
51. On 17 September, following a targeted search of Mr Scholick's cell, staff found two mobile phones, an improvised charger and a quantity of tablets.
52. On 18 September, at 3.50am, Mr Scholick was found to be under the influence of illicit drugs. He had self-harmed by making a superficial cut to his neck with a plastic knife. Mr Scholick declined any treatment from healthcare staff. An officer opened an ACCT.
53. A CM saw Mr Scholick and completed an immediate action plan. He assessed Mr Scholick as being at raised risk and set his level of observations at hourly throughout the day and night until the first case review.
54. Throughout the remainder of the day, A SO attempted to hold the assessment and first ACCT case review with Mr Scholick. Mr Scholick refused to participate in the ACCT review. He recorded that he had tried to persuade Mr Scholick to participate in the ACCT process but that he was under the influence of an illicit substance. Mr Scholick was not happy that two phones and a quantity of tablets had been removed by staff
55. The SO assessed Mr Scholick as being at raised risk of suicide and self-harm, and kept the level of observations at hourly throughout the day and night. Mr Seed completed the ACCT caremap which contained one action: that Mr Scholick would work with the mental health team. The next review was set for 19 September.
56. On 19 September, a SO attempted to chair an ACCT review with an officer but Mr Scholick was out at court, so SO Maddison rescheduled the review for the

following day. Mr Scholick appeared at Newcastle Crown Court, remained on remand, and was listed to appear in court again on 19 October.

57. On 20 September, a SO chaired an ACCT review with a nurse and Mr Scholick present. Mr Scholick said he was worried about his girlfriend. He agreed to work with the mental health team. She and the nurse assessed that Mr Scholick was at low risk of self-harm and reduced the level of observations to three observations in the morning, afternoon, evening and during the night. She set the next review for 24 September.
58. On 24 September, the SO chaired an ACCT review with a nurse from the mental health team and Mr Scholick present. Mr Scholick said he felt "ok", had no thoughts of self-harm or suicide and would speak to staff if necessary. He said he was due back in court on 19 October, and expected to be released. Mr Scholick said he no longer wanted to work with the mental health team.
59. The SO and the nurse from the mental health team assessed that Mr Robertson was at low risk of self-harm and agreed to close the ACCT. She updated the caremap that the action was completed. The nurse from the mental health team discharged Mr Scholick from mental health care. A post-closure interview was set for 1 October.
60. A SO told the investigator that, in his capacity as wing manager, he knew there was no intelligence or evidence that Mr Scholick was being bullied. He said that Mr Scholick was happy sharing a cell with his cellmate, as they were friends and knew one another outside prison. He said that at no point did Mr Scholick approach staff to request a move to a different cell from his cellmate.

### Events of 29 September 2018

61. On 29 September, at 9.16am, Mr Scholick's cellmate pressed the cell bell to alert staff that he could not wake Mr Scholick. A prisoner and wing cleaner was on the landing by the cell and also shouted for staff. An officer radioed a code blue emergency, which indicates a prisoner is unconscious or having difficulty breathing and an ambulance was called immediately. She said Mr Scholick was lying in his bed, on the top bunk, and was unresponsive. Mr Scholick's cellmate said Mr Scholick had taken "something" the night before.
62. A nurse arrived in under 60 seconds but did not start cardiopulmonary resuscitation (CPR). She told the investigator that she did not start CPR as rigor mortis was clearly evident, which indicated that Mr Scholick had been dead for some time, and to start CPR would have been futile and undignified. Paramedics arrived at 9.30am and at 9.32am, they pronounced Mr Scholick dead.
63. Mr Scholick's cellmate was interviewed, under caution, by Durham Police. The police informed the investigator that he gave a 'no comment' interview. The police said that there was no evidence to justify beginning any criminal proceedings against him in connection with Mr Scholick's death.

## **Post-mortem report**

64. A post-mortem examination conducted by a Home Office Forensic Pathologist confirmed that the cause of Mr Scholick's death was cardio-respiratory arrest. Toxicology results confirmed that Mr Scholick had taken 5F-ADB (a synthetic cannabinoid, commonly referred to as 'spice'), pregabalin and diazepam (prescription-only drugs used for anxiety, insomnia and alcohol withdrawal) at some point before his death. These drugs had not been prescribed to Mr Scholick. The report concluded that it was possible this combination of drugs contributed to Mr Scholick's death.

## **Contact with Mr Scholick's family**

65. Mr Scholick had nominated his mother as his next of kin. On 29 September, at 11.45am, a family liaison officer from HMP Durham received a phone call from Mr Scholick's mother. She said that a prisoner had contacted the family to tell them that her son had died. He broke the news that Mr Scholick had died. As Mr Scholick's mother was not at home, he and a SO arranged to visit her at her home address at 2.20pm that afternoon to give the details of her son's death and to offer condolences. In the days that followed, Durham maintained contact with Mr Scholick's mother and in line with Prison Service instructions, the prison contributed to the costs of the funeral.

## **Support for prisoners and staff**

66. Head of Safer Custody, held a debrief for staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and for managers to offer support. The staff care team also offered support.
67. The prison posted notices informing staff and prisoners of Mr Scholick's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Scholick's death.

# Findings

## Illicit Substances

68. Toxicology results show that Mr Scholick had used three illicit substances at some time before his death, both PS and prescription-only drugs which he had not been prescribed. The pathologist concluded that this combination of drugs may have contributed to Mr Scholick's death.
69. Mr Scholick had a significant history of illicit drug use. After his arrival at Durham on 14 May, he was monitored for withdrawal symptoms. He was appropriately referred to the substance misuse team for support and advice but he refused to engage with them. It appears that he continued to use illicit drugs at Durham.
70. Mr Scholick died during HMIP's inspection of Durham in September/October 2018, one of six drug-related deaths at Durham in 2018. In his subsequent report, HM Chief Inspector of Prisons was concerned that safety at Durham had been seriously compromised by the ready availability of illicit drugs.
71. The prison has a comprehensive *Drug and Alcohol Pathway Policy*, which includes measures to reduce the demand and supply of illicit drugs, and a *Reception and Treatment Pathway for Substance Misusers*. We are concerned that, despite this, Mr Scholick was able to obtain both PS and illicit prescription medication while in Durham. Although staff acted on intelligence and found illicit drugs in Mr Scholick's cell on two occasions (in July and September), he was clearly successful in continuing to obtain drugs. This suggests that much more needs to be done to tackle the issue of drugs at Durham.
72. Drug-taking and trading is a serious problem across much of the prison estate. Individual prisons are for the most part doing their best to tackle the problem by developing their own local drug strategies. However, the PPO has called for national guidance to prisons from HMPPS providing evidence-based advice on what works, and we welcome the fact that such guidance has now been issued, together with a Prison Service strategy to reduce the supply of and demand for drugs in prisons.
73. In relation to reducing the supply of drugs, the Prison Service strategy says:

“Every prison is different, and will benefit from tools to assess their specific security needs. We have worked with prisons to carry out Vulnerability Assessments in prisons to build a picture of the security risks and enable establishments to better target their resources to tackle them. This resource will continue to be offered across the estate. The Drug Diagnostic toolkit used for the prisons in the 10 Prisons Project has also proved to be useful in identifying key issues in different establishments and so we will share this for use across the whole estate, supporting prisons to identify where changes could have the greatest impact.”

We, therefore, recommend:

**The Governor should ensure that the key drug issues at Durham are identified and that the prison's local drugs strategy is revised to ensure that these key issues are being addressed, including the trafficking and trading of prescription medication.**

**The Prison Group Director for Tyne and Wear should satisfy himself that Durham is taking appropriate action to address the supply of and demand for drugs, and report his conclusions to the Ombudsman.**

### **Management of risk of suicide and self-harm**

74. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*, which sets out the Prison Service's framework for delivering safer custody procedures, lists a number of risk factors and potential triggers for suicide and self-harm. These include a prisoner's first time in custody, recall to custody, early days in custody, previous self-harm, being charged with a violent offence, a history of alcohol or drug abuse and court appearances, especially at the start of a trial and sentencing. Staff should interview new prisoners in reception to assess their risk of suicide or self-harm. All staff should be alert to the increased risk of self-harm or suicide posed by prisoners with these risk factors and should act appropriately to address any concerns, including opening an ACCT if necessary.
75. Mr Scholick had some recognised risk factors in that he had a history of drug abuse and mental ill health. We are satisfied that ACCT procedures were appropriately opened in July and September when Mr Scholick self-harmed after becoming distressed about his father's health and his relationship with his girlfriend. We found that ACCT procedures at Durham were correctly conducted in line with mandatory national instructions and that case reviews were multidisciplinary.
76. We consider that the ACCT may have been closed prematurely in September as there is no evidence that Mr Scholick's problems with his girlfriend had been resolved and he had refused to engage with the mental health team. However, we are satisfied that staff had no reason to believe that Mr Scholick was being bullied by his cellmate (as his mother has suggested). We cannot say with complete certainty that he was not being bullied, but we can say that, although Mr Scholick discussed other concerns with staff, he never suggested to them he was being bullied or asked for a cell move.
77. We are also satisfied that there is no evidence that Mr Scholick's death was suicide.

### **Clinical care**

78. The clinical reviewer, judged that the care that Mr Scholick received from healthcare staff at Durham was equivalent to the care he would have received in the community. He comments that Mr Scholick had a long history of substance misuse, alongside an undetermined mental health issue. Mr

Scholick was found under the influence of illicit substances on several occasions but he refused any intervention from substance misuse services.

79. The clinical reviewer found no concerns with the mental health care provided by Durham. He was also satisfied that healthcare staff were correct not to start resuscitation, in line with NHS England guidelines, as rigor mortis was present.

#### **Contact with Mr Scholick's family**

80. When prisoners enter prison, they are asked to provide names and contact details for one or more next of kin who will be informed if they become seriously ill or die. When a prisoner dies in custody, Prison Service Order (PSO) 2710, *Follow up to deaths in custody*, requires the prison to inform the prisoner's nominated "next of kin and any other person the prisoner has reasonably requested be informed". Mr Scholick had named his mother as his next of kin and the prison appropriately informed her of his death. He had not named his father and the prison did not, therefore, contact him.

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations