

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Liam Murray, a prisoner at HMP Durham, on 14 January 2020

**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*



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

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

Mr Liam Murray died on 14 January 2020, after being found hanging in his cell at HMP Durham. He was 27 years old. I offer my condolences to Mr Murray's family and friends.

Mr Murray gave little indication that he was at risk of suicide and self-harm when he arrived at Durham on 2 January. I consider it reasonable that staff did not start suicide and self-harm prevention procedures, but they failed to record their full reasoning for their decision, including the risk factors they had identified and considered.

I am concerned that Mr Murray's telephone PIN was not activated during his 12 days at Durham, which meant that he was unable to make telephone calls. Staff made an unintentional error when setting up Mr Murray's PIN. Mr Murray raised his inability to make telephone calls with staff several times, including with his key worker two days before he died. I consider that his key worker should have taken proactive steps to try to resolve the issue with Mr Murray's PIN.

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**

**October 2020**

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# Summary

## Events

1. On 2 January 2020, Mr Liam Murray was remanded in prison custody, charged with the murder of his partner, and sent to HMP Durham. This was not his first time in prison.
2. Mr Murray arrived at Durham with no self-harm warnings. An officer carried out his reception screening and a nurse carried out his reception health screen. Neither considered that Mr Murray was at risk of suicide and self-harm, though the nurse referred him for an urgent mental health assessment given the nature of his alleged offence. A nurse assessed Mr Murray on 4 January and identified no mental illness.
3. At around 3.55pm on 14 January, a prisoner saw Mr Murray hanging from a light fitting in his cell and shouted to staff. Officers responded, called a medical emergency code and started cardiopulmonary resuscitation (CPR). Nurses attended and assisted with resuscitation attempts until ambulance paramedics arrived. Paramedics were unable to resuscitate Mr Murray and declared his death at 4.41pm.

## Findings

4. Mr Murray gave little indication that he was at risk of suicide and self-harm when he arrived at Durham, though his alleged offence was a risk factor. We consider it reasonable that staff did not start suicide and self-harm prevention procedures (known as ACCT). However, staff failed to record their full reasoning for not starting ACCT procedures, including the risk factors they had identified and considered.
5. Mr Murray's telephone PIN was never activated during his 12 days at Durham, due to an error made by the PIN clerk when setting up his PIN on the prison's system. Mr Murray raised his inability to make telephone calls with staff several times. On 12 January, he told his key worker, who said that his telephone numbers were still being cleared by security. This was not the reason for the delay and we consider that Mr Murray's key worker should have taken proactive steps to try to resolve the issue with Mr Murray's PIN.
6. The clinical reviewer found that Mr Murray was not offered a secondary health screen within seven days as he should have been. This would have been another opportunity for Mr Murray to tell staff how he was feeling.
7. The nurse who carried out Mr Murray's mental health assessment noted that he needed further monitoring. However, she did not schedule a date for review or note how she planned to monitor him.

## Recommendations

- The Governor and Head of Healthcare should ensure that reception staff:
  - are familiar with the suicide and self-harm risk factors and triggers as set out in PSI 64/2011;
  - consider and record all known risk factors of a newly-arrived prisoner when determining their risk of suicide and self-harm; and
  - document the information considered and the reasons for their decision on whether or not to start ACCT procedures.
- The Governor should ensure that key workers are aware of what is expected of them in their key working role and that key workers take proactive steps to help resolve issues prisoners raise with them.
- The Governor should share this report with an officer and ensure that a senior manager discusses the Ombudsman's findings with him.
- The Head of Healthcare should ensure all prisoners are offered a Secondary Reception Screen in line with Nice Guidance NG57.
- The Manager for Mental Health Services should review the assessment process to ensure that staff review the prisoner's medical record prior to assessment and that care plans are documented following assessment.

## The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Durham informing them of the investigation and asking anyone with relevant information to contact her.
9. The investigator visited Durham on 21 January 2020. She obtained copies of relevant extracts from Mr Murray's prison and medical records and interviewed two prisoners.
10. The investigator interviewed eleven members of staff and two prisoners between February and May 2020. NHS England commissioned an independent clinical reviewer to review Mr Murray's clinical care at the prison. They jointly interviewed healthcare staff.
11. We informed HM Coroner for County Durham and Darlington of the investigation. He gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
12. One of the Ombudsman's family liaison officers contacted Mr Murray's next of kin, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Murray's next of kin asked:
  - What did the prison know about Mr Murray's mental health issues and what did they do about them? (She said he had psychosis and anxiety.)
  - Did he have a mental health assessment?
  - What medication was he receiving?
  - Was Mr Murray on suicide watch and how did he hang himself if so?
  - What did Mr Murray use to hang himself and where did he get the ligature from?
  - What was done about Mr Murray's complaint regarding death threats?
  - Why did it take the prison so long to respond to Mr Murray's complaint?

We have covered these issues in the report. Mr Murray's next of kin raised some other issues, outside the remit of our investigation, which have been dealt with in separate correspondence.
13. Mr Murray's family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.
14. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

## Background Information

### HMP Durham

15. HMP Durham, which holds up to 996 men, is a local prison serving the courts of Durham, Tyneside and Cumbria. G4S provides primary nursing and clinical drug and alcohol services. Spectrum Healthcare provides GP and pharmacy services and Tees, Esk and Wear Valley NHS Trust provide mental health services.

### HM Inspectorate of Prisons

16. The most recent full inspection of HMP Durham was in September and October 2018. Inspectors' overriding concern was the lack of safety in the prison. Since their last inspection in 2016, there had been seven self-inflicted deaths, and inspectors were disappointed that the prison's response to the PPO's recommendations had not been addressed with any vigour or urgency. Inspectors concluded that PPO recommendations were not sufficiently prioritised.
17. HMIP carried out an Independent Review of Progress in July 2019 to review the progress made in achieving the key recommendations from the 2018 inspection. They found that weaknesses in the suicide and self-harm prevention measures remained a significant concern and required urgent attention. Three prisoners had taken their own lives in the last nine months and attention to reviewing the implementation of PPO recommendations from previous reports was still insufficient. Despite efforts to improve the quality of ACCT, procedures were not yet delivered well enough to provide effective care. More multidisciplinary planning and working were required to safeguard prisoners in crisis who had complex personal needs or were repeatedly self-harming.

### Independent Monitoring Board

18. 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 ending 31 October 2019, the IMB noted that incidents of self-harm had increased, as had the number of ACCTs opened. The Board found that over the last six months, the percentage of secondary health screenings carried out within seven days had increased.

### Previous deaths at HMP Durham

19. Mr Murray was the 18th prisoner to die at Durham since January 2018. Of the previous deaths, seven were self-inflicted, six were from natural causes and four were drug-related. We have made recommendations before about reception staff failing to note prisoners' risk factors for suicide and self-harm and not recording the reasons for their decision not to start ACCT procedures. We have also made a previous recommendation about the operation of the key worker scheme at Durham.

## Assessment, Care in Custody and Teamwork

20. 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.
21. 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. As part of the process, a caremap (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.
22. 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.

## The key worker system

23. The key worker system is a key part of HMPPS's response to self-inflicted deaths, self-harm and violence in prisons. It is intended to improve safety by engaging with people, building better relationships between staff and prisoners and helping people settle into life in prison. Details of how the system should work are set out in HMPPS's *Manage the Custodial Sentence Policy Framework*. This says:
  - All prisoners in the male closed estate must be allocated a key worker whose responsibility is to engage, motivate and support them through the custodial period.
  - Key workers must have completed the required training.
  - Governors in the male closed estate must ensure that time is made available for an average of 45 minutes per prisoner per week for delivery of the key worker role, which includes individual time with each prisoner.
  - Within this allocated time, key workers can vary individual sessions in order to provide a responsive service, reflecting the prisoner's individual need and stage in the sentence. A key worker session can consist of a structured interview or a range of activities such as attending an ACCT review, meeting family during a visit or engaging in conversation during an activity to build relationships.

## Key Events

24. On 2 January 2020, Mr Liam Murray was remanded in prison custody, charged with the murder of his partner, and sent to HMP Durham. This was not his first time in prison.
25. Mr Murray arrived at Durham at around 2.45pm. His Person Escort Record (PER – a document that accompanies prisoners between police custody, courts and prisons, which sets out the risks they pose - noted that Mr Murray had anxiety, depression and psychosis. GEO Amey escorting officers had recorded on the PER at 8.25am, that Mr Murray had no thoughts of self-harm and at 1.21pm, that he was chatty, made good eye contact and presented no immediate concerns.
26. A Senior Officer (SO) carried out Mr Murray's reception screening. He noted that no self-harm warning forms were attached to the PER and that Mr Murray had no thoughts of self-harm. On the screening form, in the section on suicide and self-harm risk indicators, he marked, 'Yes' to the question, 'Is the prisoner's alleged offence against a partner/family member?' and wrote 'Partner'. He also marked 'Yes' to the question, 'Is the prisoner on remand for an offence that raises concern (serious sexual offences, high media profile, expecting a 10-year plus sentence or received sentence unexpectedly?)' and wrote 'Murder'. He noted that Mr Murray had been in prison before and wanted a cellmate to keep him company.
27. A nurse carried out Mr Murray's reception health screen. She noted that he was being treated for anxiety and depression but had no thoughts of suicide or self-harm. She recorded that Mr Murray engaged well, had good eye contact and his mood was stable. She referred him for an urgent mental health assessment because of his alleged offence and noted, 'Offence is murder and has not yet been assessed by the in-reach mental health team.'
28. A prison GP saw Mr Murray and noted that he looked fine and his mood was stable. He prescribed Mr Murray citalopram (antidepressant) but decided not to prescribe propranolol (for anxiety) until the dose could be checked in his GP records. (His GP records were requested the next day and received on 6 January, when a prison GP prescribed 40mg of propranolol per day.)
29. Mr Murray declined support from Change Grow Live (the non-clinical drug and alcohol team) and signed a disclaimer.
30. Mr Murray was located on the First Night Centre in a shared cell. An officer carried out his induction. He noted that Mr Murray was in a good mood, presented well and had no thoughts of suicide or self-harm. The officer gave Mr Murray his temporary phone PIN which was credited with the standard £2 credit. (All prisoners are given a PIN which they must enter before they can dial a telephone number.)
31. As Mr Murray had been charged with murder, his PIN would have been restricted and he would not have been able to make any calls until the numbers he requested had been cleared by security. The officer told the investigator that it usually took security four to five days to clear numbers and he told Mr Murray this.

32. On 3 January, a PIN clerk changed Mr Murray's temporary PIN to his permanent PIN, by entering his prison number. However, she made an error when inputting his prison number, replacing an 'A' with a '7'. This meant that the system would not have recognised Mr Murray as a user and he would have been unable to make calls. The PIN phone system does not alert clerks when an invalid prison number has been input, so the PIN clerk did not realise her mistake. When done correctly, the transition between a temporary and permanent PIN should happen the next working day.
33. At 7.59am, a substance misuse support worker recorded that Mr Murray was offered but declined Drug and Alcohol Recovery Team (DART) support. She gave him harm minimisation advice and he saw a peer mentor at the prisoner information desk. He did not wish to have any further involvement with substance misuse services and this was the last time he was seen by them.
34. At 9.57am, a prison chaplain recorded that he had seen Mr Murray and there were no immediate concerns.
35. At 12.12pm, an officer recorded that Mr Murray had attended a court hearing via videolink and had been further remanded until 29 January. He recorded that Mr Murray was okay with that.
36. At 4.35pm, a mental health nurse recorded on Mr Murray's medical record (SystmOne) that she had done a desk top review of the mental health referral form and Mr Murray's medical record. She noted that he would be seen by a mental health duty worker and requested a CPA (Care Planning Approach) check to see if he would be open to using services. (He said on 7 January that he was not.)
37. On 4 January (time unknown), the cellmate's PIN was used to make a two-minute phone call to Mr Murray's next of kin.
38. On 4 January, at 10.32am, a nurse recorded on SystmOne that she had completed the urgent mental health assessment of Mr Murray on the wing. Mr Murray told her that he had a history of drug induced psychosis and that in the past 12 months he had started to feel increasingly paranoid. He said that these symptoms had started after the birth of his third child and when he had started to smoke cannabis daily. He told her that he was engaged with the non-clinical DART team (though he was not).
39. Mr Murray said he was paranoid that other people were talking about him and though he was able to distract himself from his paranoid thoughts, he was finding it increasingly difficult to do so and felt very stressed. Mr Murray said that he was managing well in the prison and that he got on with his cellmate, but that his phone PIN was not working so he had not been able to speak to his family.
40. A nurse noted that Mr Murray was well-kempt and said he had no thoughts of suicide or self-harm. She noted that she had identified no mental illness but that further assessment and monitoring was required. She advised him to speak to wing staff about his phone PIN. She did not make an appointment to see him further or make any arrangements to monitor him.

41. At interview, the nurse said that in her clinical judgement, she considered that Mr Murray was not a risk to himself: he denied any risk to himself, highlighted protective factors and demonstrated future planning. She had no reason to think that Mr Murray intended to harm himself and therefore considered ACCT procedures were not necessary. She said she had planned to see him again in four weeks.
42. On 5 January, Mr Murray applied to have three numbers added to his PIN phone account – his mother’s and two numbers for his next of kin. On the same day, Mr Burden’s PIN was again used to make a call to Mr Murray’s next of kin.
43. On 7 January, Mr Murray’s offender manager interviewed Mr Murray as part of ‘Through the Gate’ mentoring and to complete Mr Murray’s Basic Custody Screening Tool (BCST). Mr Murray declined to engage fully with the interview saying that the questions were irrelevant as he was going to get a long sentence.
44. She noted that Mr Murray was emotional when talking about his children and he was not sure where they were. She asked Mr Murray if he was feeling okay and he told her he was managing okay but did not wish to continue with the interview. She walked him back to his cell and asked him again if he was okay and he said he was. His offender manager noted that she told a SO on the wing that Mr Murray had declined to complete the interview and had become emotional when talking about his children.
45. On 8 January, Mr Murray was moved from E Wing to B Wing where he shared a cell.
46. On 8 January, Mr Murray’s offender manager attempted to discuss drugs and alcohol with Mr Murray. She told the investigator that he was upbeat, and they shared a joke about the wing floor resembling an ice-rink having just been cleaned. Mr Murray said he had no issues and only used cannabis occasionally. (Previous records suggested he had been diagnosed with drug-induced psychosis at 18.)
47. At interview, the investigator asked Mr Murray’s offender manager whether Mr Murray had mentioned any issues with his phone PIN. She said he told her that his PIN was not working and that she told him it could take some time to sort out, particularly if he had come in near to or over a weekend (he had arrived on a Thursday). She recommended that he speak to his landing officer about it as it was not a matter she could resolve. She told the investigator that she also spoke to the landing officer herself (or who she assumed was the landing officer as they had unlocked Mr Murray) to let them know that Mr Murray would be raising it with them when he was next on association.
48. Mr Murray’s offender manager told the investigator that apart from becoming emotional when talking about his children, Mr Murray seemed okay and she did not consider that starting ACCT procedures was necessary.
49. On 8 January, Mr Murray completed a statement saying that individuals connected to the victim of his offence were on the same wing as him and threatening to harm him: ‘I have already been told I’m going to get sliced up.’ He

did not submit this statement but kept it in his cell. (The investigator found the original copy in Mr Murray's cell.)

50. There was no evidence Mr Murray had submitted the statement, no incidents of bullying were logged anywhere on his record and none of the staff the investigator spoke to, or his second cellmate, said Mr Murray ever mentioned this. (Mr Murray's first cellmate had moved prisons and was subsequently released.)
51. On 8 January, Mr Murray completed a prison complaint form. He said that he had not been able to make any phone calls since he had arrived at the prison. He had not even been able to use the £2 credit when he first arrived. He said he was expecting a life sentence and not being able to speak to anyone was making it hard for him to cope. He said he just wanted to be able to ring his family and find out where his children were. It is not known exactly when he submitted it, but it is thought that he might have done so around 10 January. Prisoners submit complaints by posting them into a locked box on the wing which is emptied daily (except at weekends). It is thought Mr Murray probably posted his complaint just before or at the weekend (so 10-12 January) as the complaint was not picked up until Monday 13 January. A reply was due by 17 January.
52. On 10 January, Mr Murray received a response to his application to have his mother's and grandmother's numbers added to his PIN phone account. It was sent to him via the prison's 'Electronic Kiosk' and advised him to speak to his landing officer to get his PIN activated.
53. On Friday 10 January, at approximately 5.00pm, Mr Murray told an officer that his PIN was not working. The officer called the PIN department, but no one was available as they had finished for the weekend. The officer told Mr Murray he would contact them again on Monday. He saw Mr Murray over the weekend and said he had not forgotten, and Mr Murray seemed okay about it.
54. On 12 January, at 11.04am, an officer recorded that he had introduced himself to Mr Murray as his key worker. (Under the key worker scheme, officers should spend an average of 45 minutes every week on key worker duties for each of their allocated prisoners, including having meaningful conversations to build rapport and discuss any ongoing issues.) He noted that Mr Murray was polite and well-presented and had applied for a job. He asked the officer about his phone PIN and the officer told him that once the security checks had been done, suitable numbers would be put on the system. However, unbeknown to the officer the problem was primarily with the incorrect inputting of Mr Murray's prison number by the PIN clerk, rather than clearing Mr Murray's telephone numbers.
55. On 13 January, an officer telephoned a PIN clerk and asked her to activate Mr Murray's PIN. The PIN clerk searched for Mr Murray on the system but could not find him (because of the initial error she had made inputting his prison number incorrectly). She telephoned the wing back to ask the officer to clarify Mr Murray's prison number and PIN in case an error had been made. An officer was not available, and the PIN clerk left a message with an unknown officer to ask them to tell the officer to call her back. She did not hear back.
56. In fact, the officer had confirmed Mr Murray's PIN number with him and had called the PIN clerks back, but they were on their lunch break. The officer was

on a half day that day and left before the PIN clerks returned. He told the investigator he handed over the issue to an officer and asked him to confirm Mr Murray's PIN with them. The officer did not recall anything about this matter or about Mr Murray, other than when he became involved in the emergency response

### Events of 14 January

57. On 14 January, an officer asked Mr Murray if his PIN had been sorted out. He said it had not and the officer said he would look into it that afternoon when he was working on the wing again (he was working on the healthcare unit in the morning). The officer returned to the wing at approximately 12.30pm, and asked another officer what had happened with Mr Murray's PIN. The officer said he had been unable to contact the PIN department because it had been so busy on the wing.
58. An officer contacted the PIN department, but the PIN clerk was away from her desk. On her return, the PIN clerk contacted the wing again. She spoke to a member of staff identified only as 'female' who took a message and said she would pass it to an officer. She did not receive a call back that day and updated a colleague in her department about the situation (as the PIN clerk had the next day booked off.)
59. Mr Murray submitted another complaint about his PIN phone which the prison picked up on 15 January – the day after his death. Mr Murray's complaint said that he had been asking officers to sort out his PIN for two weeks and that he had been unable to make any calls at all since he had been in prison. He said, 'My mental health is deteriorating fast as I haven't been able to speak to my family'.
60. Mr Murray wrote letters to his next of kin's and another person on unknown dates (but probably between 13 and 14 January) asking them to contact him. In one of the letters he said he was unable to make any calls, that he had raised it with officers, but they were fobbing him off – he said his head was 'done in'. These letters were pulled from the prison's postal system after his death and never sent. (His mother received one of Mr Murray's previous letters on 15 January.)
61. Mr Murray's cellmate went to work at around 8.45am and returned at around 11.00am. He told the investigator that he had no concerns about Mr Murray that day. He said they chatted about normal things and he thought Mr Murray might have had a visit scheduled for that afternoon (he did – a police visit which was cancelled). He said that Mr Murray had no problems with other prisoners as far as he was aware and was not involved with drugs. He said that Mr Murray was concerned about his offence and what people thought about him, and about his phone PIN not working. He went back to work around 2.00pm.
62. At 2.30pm, an officer asked Mr Murray if he wanted to take some exercise. The officer said at interview that he was unable to remember what Mr Murray had said or what he had seen in his cell. He said that generally he would always seek to get a response from a prisoner about exercise.

## The emergency response

63. At approximately 3.55pm, a prisoner went to Mr Murray's cell looking for his friend. He looked through the observation panel, but it was dark in the cell, so he turned the night light on. At first, he thought Mr Murray was just standing in the middle of the room, but then he saw the ligature around his neck (a bed sheet attached to a light fitting) and shouted to officers.
64. Two officers responded immediately and at 3.56pm, an officer called a code blue (a medical emergency code used to indicate that a prisoner is unconscious or having breathing difficulties). Control room staff immediately called an ambulance. An officer went straight into the cell and lifted Mr Murray's feet off the ground to relieve the pressure of the ligature from around his neck. He then cut the ligature with his safety knife and laid Mr Murray on the floor. He checked to see if he was breathing and for a pulse, and found Mr Murray did not have a pulse.
65. An Operational Support Grade (OSG), was in the control room and unable to provide emergency services with much detail, but an ambulance was despatched. He called emergency services back at 3.58pm to give them more details about Mr Murray.
66. An officer arrived at Mr Murray's cell and another officer asked him if he knew how to do cardiopulmonary resuscitation (CPR), which he did. Mr Murray was on the floor at this point and an officer described him as 'sort of cold to the touch,' and that his jaw was 'quite stiff'. An officer checked Mr Murray's airway for any restrictions (he found none) and if he was breathing (he was not).
67. A Custodial Manager (CM) arrived with a facemask and an officer started CPR with him.
68. A nurse was in the segregation unit dispensing medication and was the first member of healthcare staff to arrive at Mr Murray's cell within a couple of minutes of the code blue being called. Officers immediately collected an emergency bag from the wing treatment room for her, followed by a defibrillator (also kept on the wing).
69. The nurse advised the officers to bring Mr Murray out of the cell and onto the landing to give them more space to work. Mr Murray was cold to the nurses' touch and she could find no evidence of a pulse or of him breathing. There were no signs of rigor mortis and she was able to insert the I-gel device to maintain Mr Murray's airway. The defibrillator machine advised no shock, and officers continued with CPR. (The defibrillator advised no shock on all three occasions it was applied.)
70. Three nurses (Hotel 2) also attended the scene. A nurse helped officers continue with CPR and a nurse helped maintain Mr Murray's airway. An officer prepared himself to take over from an officer, but paramedics arrived.
71. The first set of paramedics arrived at the prison at 4.05pm and were at the scene by 4.08pm. Two further sets of paramedics arrived at the prison and efforts to resuscitate Mr Murray continued. However, they were unsuccessful, and paramedics declared Mr Murray's death at 4.41pm.

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

72. On 14 January, the prison appointed their prison chaplain, as the family liaison officer (FLO). He visited Mr Murray's family that evening with officer to break the news.
73. Mr Murray's funeral was on 30 January and the FLO took the service. The prison contributed to the funeral costs in line with national policy.

### **Support for prisoners and staff**

74. After Mr Murray's death, the Deputy Governor 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.
75. The prison posted notices informing other prisoners of Mr Murray'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 Murray's death. Two prisoners told the investigator they had received a lot of support after the event.

### **Post-mortem report**

76. The post-mortem report concluded that Mr Murray died from compression of the neck caused by hanging. The results of toxicology tests were not available at the time of issuing this report.

# Findings

## Assessment of Mr Murray's risk of suicide and self-harm

1. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*, sets out the procedures (known as ACCT) that staff should follow if they assess that a prisoner is at risk of suicide and self-harm. The PSI contains a list of risk factors and potential triggers for suicide and self-harm. These include mental illness, including depression, and being charged with a violent offence, particularly against a family member or partner, both of which applied to Mr Murray.
2. A SO carried out Mr Murray's reception screening. He recorded that Mr Murray had been remanded for the murder of his partner, that he had been in prison before and that he had no thoughts of self-harm.
3. The SO noted Mr Murray had been charged with the murder of his partner in the risk indicators section of the SASH form. However, when asked about this at interview, the SO did not seem to be aware that a violent offence, particularly against a family member or partner, is a risk factor for suicide and self-harm.
4. A nurse carried out Mr Murray's reception health screen. She referred him for an urgent mental health assessment because of the nature of his alleged offence. However, she did not record whether she had considered starting ACCT procedures, and if she had, her reasoning for not doing so. (She could not be interviewed because she emigrated to the USA shortly after Mr Murray's death, and her contact details are not known.)
5. While Mr Murray did have some risk factors for suicide and self-harm, we consider that it was reasonable for reception staff to decide that ACCT procedures were not necessary. However, neither the SO nor a nurse recorded their consideration of Mr Murray's risk factors or the reasons for their decisions not to start ACCT procedures. Also, while the nurse referred Mr Murray for a mental health assessment because of the nature of his offence, it was not clear to us whether either she or the SO were aware that his alleged offence was a risk factor for suicide and self-harm. We make the following recommendation:

### **The Governor and Head of Healthcare should ensure that reception staff:**

- **are familiar with the suicide and self-harm risk factors and triggers as set out in PSI 64/2011;**
- **consider and record all known risk factors of a newly-arrived prisoner when determining their risk of suicide and self-harm; and**
- **document the information considered and the reasons for their decision on whether or not to start ACCT procedures.**

## Failure to activate PIN account

6. Mr Murray's PIN phone account was never activated during his 12 days at Durham. When his PIN was being set up on the system, the PIN clerk inputted Mr Murray's prison number incorrectly. The system did not alert the clerk that she had inputted an invalid number, so she was unaware of her mistake.
7. Mr Murray told staff on several occasions about his lack of PIN and inability to make telephone calls. On 8 January, he told his offender manager, who advised him to speak to the landing officer. She told the investigator that she spoke to the landing officer herself and said Mr Murray would raise it with them during association. It is unclear whether he did so.
8. On Friday 10 January, Mr Murray told an officer, who called the PIN department, but it had closed for the weekend. On 12 January, Mr Murray asked his key worker, an officer, about his PIN. The officer told him that once the security checks had been done, his numbers would be put on the system and he would be able to make calls.
9. PSI 49/2011, *Prisoner Communication Services*, says, 'The Prison Rules require prisons to actively encourage prisoners to maintain outside contacts and meaningful family ties.' PSI 64/2011, Chapter 13 says that HMPPS, '...recognises that strong support from families and friends can make an enormous difference to prisoners who are at risk of harm to themselves, to others and/or from others. Families can provide vital information to prison staff about a prisoner's well-being, particularly if they are feeling depressed or suicidal.'
10. We accept that a mistake was made when setting up Mr Murray's PIN. Nevertheless, in our view it is unacceptable that during his 12 days at Durham, Mr Murray's PIN was never activated, and he was unable to make telephone calls. Mr Murray raised it with staff repeatedly. When he raised it with an officer, it was unfortunately too late on a Friday for the officer to contact the PIN department, though he did pursue this on the Monday.
11. We are concerned that when Mr Murray raised his lack of PIN with his key worker, an officer, on 12 January, the officer told him that his numbers were still being cleared. Given this was 10 days after Mr Murray had arrived at Durham, we consider that the officer should have made attempts to find out what was happening.
12. There were an unfortunate series of events that led to Mr Murray having no PIN to make telephone calls, but we consider that his key worker should have been more proactive when Mr Murray told him that he still had no PIN. We make the following recommendations:

**The Governor should ensure that key workers are aware of what is expected of them in their key working role and that key workers take proactive steps to help resolve issues prisoners raise with them.**

**The Governor should share this report with an officer and ensure that a senior manager discusses the Ombudsman's findings with him.**

## Clinical care

13. The clinical reviewer concluded that the clinical care Mr Murray received was equivalent to that he could have expected to receive in the community although he did identify some areas for improvement.
14. Although Mr Murray had a reception health screen, there is no evidence that Mr Murray was offered a second reception screen within seven days as he should have been. We consider that this could have been another opportunity for Mr Murray to speak to staff and maybe tell them how he was feeling. We make the following recommendation:

**The Head of Healthcare should ensure all prisoners are offered a Secondary Reception Screen in line with Nice Guidance NG57.**

15. A nurse appropriately referred Mr Murray for an urgent mental health assessment when he arrived at Durham. The initial triage was carried out by a nurse and was only a desktop review. Mr Murray was then assessed by a nurse the following day. The clinical reviewer noted that he was pleased that desktop reviews have been phased out at Durham (all are now face to face) as essentially this led to a short delay in Mr Murray being assessed. He was not seen for his urgent assessment until two days after he arrived at Durham.
16. A nurse assessed Mr Murray on 4 January. She considered that he showed no evidence of mental illness or presented any significant risks, but she noted that further monitoring was necessary to establish the basis of his paranoid thoughts. However, there is no evidence to show how she intended to monitor him further and she did not set a date for another review.
17. At interview, the nurse said she kept Mr Murray on her caseload because he had spoken of past paranoia. She was unsure whether that was a purely historical thing or something more recent (a result of attention because of his offence) so had wanted to see what developed. She said that she had not booked a further appointment in with him, but she had planned to see him in the next four weeks. She said she usually reviewed her cases once a month and booked any further review appointments in at that point but was vague about when she would have done this for January.
18. The nurse also discussed Mr Murray's cannabis use with him as he had suggested his mental health had deteriorated in tandem with its use. However, he also told the nurse he was engaging with Change Grow Live (CGL) which he was not. The nurse did not refer to CGL records, so she was not aware this was untrue. We make the following recommendation:

**The Manager for Mental Health Services should review the assessment process to ensure that staff review the prisoner's medical record prior to assessment and that care plans are documented following assessment.**

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations