Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Trevor Green, a prisoner at HMP Durham, on 21 July 2020

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

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk
T I 020 7633 4100
F I 020 7633 4141

## 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 we oversee can improve their work in the future.

Mr Trevor Green was found hanging in his cell at HMP Durham on 21 July 2020. He was 44 years old. I offer my condolences to Mr Green's family and friends.

I am very concerned that staff did not start Prison Service suicide and self-harm monitoring (known as ACCT) for Mr Green when he arrived at Durham on 20 July, despite him having several risk factors for suicide. I am also concerned that documents describing these risk factors were not available to prison and healthcare staff who completed induction interviews, health assessments and mental health triages.

Prison staff started ACCT monitoring around two hours before Mr Green's death, but I am concerned that they did not manage it in line with national guidance.

I am also concerned that when control room staff called for an ambulance, they gave incomplete information about Mr Green's condition, which meant that initially the Ambulance Service did not treat the incident as life-threatening and there was a delay in sending an ambulance to treat Mr Green.

This is the fifth investigation in the last two years in which we have expressed concerns about Durham's failure to identify those at risk of suicide and self-harm when they arrive. The Governor must take urgent action to resolve this problem.

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** **March 2021**

## Contents

# Summary

## Events

1. On 20 July 2020, Mr Trevor Green was remanded in prison custody, charged with the murder of his partner, and sent to HMP Durham. Mr Green arrived with a Suicide and Self-Harm Warning (SASH) form that noted that he had tried to strangle himself and had cut his left arm in the past month.

2. The reception officer noted that Mr Green said he had no thoughts of suicide or self-harm, that he had interacted well and that he kept good eye contact. The reception officer decided not to start Prison Service suicide and self-harm monitoring (known as ACCT). Prison staff moved Mr Green to E Wing.

3. Later that evening, an officer and a nurse saw Mr Green on E Wing and both noted that he said he had no thoughts of suicide or self-harm. Neither the officer nor the nurse saw Mr Green's SASH form.

4. At approximately 11.00am on 21 July, an officer escorted Mr Green to the video link department for a court appearance.

5. At 11.20am, following a discussion between a prison manager in security and the Head of Residence and Safety about Mr Green's risk of suicide and self-harm given the nature of his offence, a prison manager on E Wing opened an ACCT for Mr Green. She set hourly observations.

6. During his court appearance, an officer from E Wing spoke to an officer in the video link department and said Mr Green had been placed on an ACCT.

7. At approximately 12.50pm, an officer escorted Mr Green back to E Wing. At 12.59pm, Mr Green entered his cell and the officer locked the cell door.

8. At 1.45pm, an officer checked on Mr Green and found him hanging from a ligature. The officer shouted for staff assistance, called a medical emergency code, entered the cell and cut the ligature. Prison and healthcare staff quickly responded. They started cardiopulmonary resuscitation, inserted an airway, gave Mr Green oxygen and attached a defibrillator.

9. The prison called for an ambulance at 1.47pm and 1.49pm. Paramedics reached Mr Green at 1.55pm but they were unable to resuscitate him and, at 2.23pm, a paramedic declared that he had died.

## Findings

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

10. Mr Green presented a high risk of suicide and self-harm when he arrived at Durham. We are concerned that his risk factors were either overlooked or not known to staff, and that this delayed staff opening an ACCT.

11. Once staff opened the ACCT, we are concerned that a prison manager did not speak to Mr Green, that the ACCT document did not follow him round the prison

as it should have done, and that staff did not follow the required level of observations.

### Emergency response

12. Although an officer correctly called a medical emergency code when he found Mr Green hanging in his cell, he did not pass relevant information about Mr Green's condition to the control room. This meant that the Ambulance Service did not initially treat the incident as life-threatening, which delayed the arrival of paramedics by four minutes.

### Post-incident actions

13. We are concerned that one officer involved in the emergency response was not involved in the hot debrief and that we only received three Incident Report Forms from the prison and healthcare staff involved in the emergency response.

14. We are also concerned that a significant telephone call between Mr Green and a friend was not retained for our investigation.

## Recommendations

- The Governor should ensure that staff manage newly arrived prisoners in line with national guidelines, including ensuring that they:
    - assess all prisoners arriving in reception and check all accompanying documents to identify any immediate needs and risks;
    - provide all accompanying documents for any interviews or assessments taking place outside reception; and
    - base their assessment of a prisoner's risk of suicide and self-harm on the prisoner's known risk factors rather than their presentation or what they say.
- The Governor should share a copy of this report with SO X and ensure that a senior manager discusses the Ombudsman's findings with her.
- The Prisons Group Director for Tees and Wear should write personally to the Ombudsman setting out what he is doing to ensure that staff at Durham have a better understanding of the principles of risk assessment for suicide and self-harm.
- The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including ensuring that:
    - a prison manager talks to a prisoner within an hour of the ACCT being opened;
    - the ACCT plan follows the prisoner around the establishment;
    - staff adhere to the frequency of observations set out in the ACCT document; and
    - staff in contact with prisoners receive appropriate ACCT training.

- The Director General of Prisons should amend Prison Service Instruction 03/2013 to reflect the national guidelines agreed between HMPPS and the Association of Ambulance Chief Executives.
- The Governor should ensure that all managers follow the national guidelines for dealing with a death in custody or serious incident, including that:
    - a debrief is held promptly after the death of a prisoner and that all staff that are involved are invited;
    - all staff directly involved in an incident should complete Incident Report Forms as soon as possible; and
    - all documentation, including any evidential telephone recordings, is retained and securely stored.
- The Governor and Head of Healthcare should ensure that any staff named in this report are given the opportunity to read the report at the initial stage in line with paragraph 1.11 of PSI 58/2010.

## The Investigation Process

15. 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.

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

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

18. The investigator interviewed 24 members of staff at Durham in October 2020. The clinical reviewer joined the investigator for nine interviews. All the interviews were conducted by telephone or video link due to the restrictions in place because of the COVID-19 pandemic.

19. 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.

20. One of the Ombudsman's family liaison officers contacted Mr Green's mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not respond to our letter.

21. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

# Background Information

### HMP Durham

22. HMP Durham, which holds up to 996 men, is a local prison serving the courts of Durham, Tyneside and Cumbria. Spectrum Healthcare provides primary health, GP, pharmacy and clinical drug and alcohol services. Tees, Esk and Wear Valley NHS Trust provides mental health services, and Humankind, a registered charity, provides non-clinical drug and alcohol services.

### HM Inspectorate of Prisons

23. 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, as they found that ACCT case management records were very poor in too many cases and core risk issues were not addressed. Inspectors found that a prisoner's risk of self-harm was explored on arrival but prison staff did not carry out a safety interview to gather information about their vulnerabilities and risks. They also found that medical emergencies were well managed, and resuscitation equipment was located across the prison.

24. The Inspectorate carried out a review in July 2019 to check the progress made in achieving the key recommendations from the 2018 inspection. Inspectors found that weaknesses in the suicide and self-harm prevention measures remained a significant concern and required urgent attention. Despite efforts to improve the quality of ACCTs, case management records remained poor, the level of risk was sometimes underestimated, and ACCTs were closed before the outcomes of actions showed a reduction in risk. They found that reasonable progress had been made in improving the initial safety checks for newly arrived prisoners, although the large numbers of new arrivals meant that it was often very difficult for staff to complete these checks thoroughly.

### Independent Monitoring Board

25. 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, though they felt that staff were increasingly vigilant to prisoners who presented with vulnerabilities. They found that the number of new arrivals at the prison continued at a high level.

### Previous deaths at HMP Durham

26. Mr Green was the 17th prisoner to die at Durham since July 2018. Seven of the previous deaths were self-inflicted, four were drug-related and five were from natural causes.

27. In four previous investigations into self-inflicted deaths in the last two years, we have expressed our concerns about Durham's failure to identify those at risk of suicide and self-harm when they arrive. We made recommendations that the Governor should address these repeated failings and ensure that improvements

are made as a matter of urgency. Following the previous death, in May 2020, we also asked the Prisons Group Director for Tees and Wear to write personally to the Ombudsman setting out what he is doing to ensure that staff at Durham have a better understanding of the principles of risk assessment for suicide and self-harm.

### Assessment, Care in Custody and Teamwork

28. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service care-planning system used to support prisoners at risk of suicide and 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.

29. 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 multidisciplinary 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.

30. 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

31. On 1 June 2020, Mr Trevor Green was remanded in prison custody on suspicion of assault and sent to HMP Durham. On 13 July, Mr Green was sentenced to 40 days imprisonment but was released immediately based on the time he had already served.

32. On 15 July, Cumbria Police arrested Mr Green and charged him with the murder of his partner. Three days later, a police officer completed a Person Escort Record (PER – a document that accompanies prisoners between police custody, courts and prisons, which sets out the risks they pose) for Mr Green's journey from a police station to Workington Magistrates' Court. The police officer wrote "slashed left arm with razor causing 6" wound – June 2020".

33. On 20 July, Mr Green was remanded in prison custody and sent to HMP Durham. Before arriving, a police officer completed a Suicide and Self-Harm Warning (SASH) form for Mr Green and noted that he had tried to strangle himself and had cut his left arm in the past month. The police officer wrote that Mr Green said he had no thoughts of self-harm, that he maintained good eye contact and had been chatty, though he had been charged with the murder of his partner.

34. At 6.50pm, shortly after Mr Green arrived at Durham, an officer signed the SASH Form. The officer told the investigator that he did not recall Mr Green or the SASH Form, although he would have asked him how he was feeling.

35. At approximately 8.30pm, a supervising officer (SO) X saw Mr Green for a reception interview and completed sections 1 to 3 of a Vulnerabilities Assessment. SO X noted that Mr Green's partner was the victim of his alleged offence, that he was on remand for that offence that raised concern and that he showed signs of withdrawing from alcohol. SO X wrote that Mr Green said he had no thoughts of suicide or self-harm and answered "no" to the question, "*Have there been any recent suicide attempts, self-harm or thoughts of either? (if so, OPEN AN ACCT…)*". She answered "yes" to the question, "*Is there any history of self-harm/ suicide attempts in the community or custody regardless of time span*", and wrote "no recent attempts" in the column alongside this question.

36. SO X noted on Mr Green's electronic prison record (known as NOMIS) that he had interacted well, kept good eye contact and that he was aware of the murder charge but "stated he was fine as it didn't happen". She did not start Prison Service suicide and self-harm monitoring (known as ACCT). Prison staff then moved Mr Green from reception to E Wing.

37. At approximately 8.50pm, an officer saw Mr Green for an induction interview and completed sections 5 to 9 of the Vulnerabilities Assessment. The officer noted that he had asked Mr Green how he was feeling, though Mr Green's response has not been recorded. The officer noted on NOMIS that Mr Green said he had no thoughts of suicide or self-harm.

38. At approximately 9.45pm, a nurse saw Mr Green for an initial health assessment. Mr Green said that he had a history of depression. The nurse noted that Mr Green engaged well and kept good eye contact. He noted that Mr Green said he

had no thoughts of suicide or self-harm and recorded "no" to the question, "*Has the patient had a change in their custodial status (e.g. licence recall, long sentence to serve, manslaughter or murder* charge)". The nurse referred Mr Green to the Drug and Alcohol Recovery Team (DART) for an alcohol intervention. The nurse told the investigator that he had not seen Mr Green's PER or SASH forms.

### 21 July 2020

39. At 7.58am on 21 July, Mr Green telephoned a friend using his cellmate's telephone account, as his own account had been restricted. The prison did not keep a recording of the telephone call so the investigator has not listened to it. However, the pathologist noted in the post-mortem report that Mr Green told his friend that he was "thinking of ending it all". We have seen no evidence that Mr Green's friend reported this to the prison at the time.

40. At 8.09am, the prison Imam saw Mr Green for a chaplaincy induction. The Imam noted in Mr Green's NOMIS record that he had not raised any issues.

41. At 9.20am, a non-clinical DART support worker spoke to Mr Green using the in-cell telephone for a non-clinical DART induction. Mr Green said that he wanted to engage with DART. He described his mood as "okayish" and said he had no current or historic thoughts of suicide or self-harm. The DART support worker told Mr Green about the risks of using illicit substances in prison and referred him to the mental health team.

42. At approximately 9.30am, a mental health clinical lead saw Mr Green for a mental health triage. She noted that Mr Green was on remand for the murder of his partner, and that he was well-kempt, engaged pleasantly and kept appropriate eye contact. Mr Green said that he had previously hurt himself by making cuts to his arm, though he said he did not have any current thoughts of suicide or self-harm and he said his two children were protective factors. He also agreed to a referral to secondary care for a comprehensive mental health assessment.

43. At approximately 10.00am, a clinical DART support worker checked on Mr Green as part of his substance misuse monitoring. Mr Green said that he had last drunk alcohol on 15 July and that he felt okay about his alcohol withdrawal. She noted that Mr Green seemed at ease.

44. A few minutes later, the clinical DART support worker telephoned the clinical lead for the Remote and Agile Team (a remote service that supports the healthcare teams at various prisons, including Durham), to discuss Mr Green's alcohol withdrawal, though she mistakenly gave details for Mr Green's cellmate, who was suffering with more severe alcohol withdrawal. The clinical lead prescribed Mr Green medication to treat his alcohol withdrawal; and asked staff to check his blood sugar levels, recorded as "BM" on his electronic medical record (known as SystmOne), and to move him to the healthcare department for monitoring.

45. At approximately 10.15am, a healthcare support worker checked on Mr Green as part of his substance misuse monitoring, and measured his blood pressure rather

than his blood sugar level. Mr Green said that he felt fine and was not experiencing any alcohol withdrawal.

46. At approximately 10.30am, Mr Green's cellmate was moved out of the cell and taken to the healthcare department to be monitored for serious alcohol withdrawal.

47. Ten minutes later, a clinical DART support worker realised her mistake, so the clinical lead cancelled part of Mr Green's prescription and his move to the healthcare department.

48. At approximately 11.00am, an officer escorted Mr Green from E Wing to the video link department for a court appearance. The officer told the investigator that he asked Mr Green whether he was on an ACCT and he laughed at the suggestion.

49. Later that morning, a prison manager in security spoke to the Head of Residence and Safety about the risks that Mr Green presented given his alleged offence, and his concern that the prison was not supporting him through the ACCT process. The Head of Residence and Safety agreed and telephoned an SO and asked her to put Mr Green on an ACCT. At 11.20am, the SO did so and noted that Mr Green was a high risk of self-harm or suicide, due to his offence being high profile and against a known victim.

50. Ten minutes later, the SO completed the ACCT immediate action plan (though she had not spoken to Mr Green) and set the level of observations at one an hour. The SO noted that Mr Green was not sharing his cell, that he did not need any healthcare intervention and that he had constant access to the Samaritans on his in-cell telephone.

51. During Mr Green's court appearance, an officer from E wing telephoned the video link department and told a second officer that Mr Green had been placed on an ACCT. The second officer told the investigator that he told other officers about this though he could not remember who these officers were, except for an officer. The ACCT document remained on E Wing.

52. At approximately 12.50pm, Mr Green's video link court appearance finished and an officer escorted him back to E Wing. Mr Green said that he had been remanded until 12 October, although he had thought he would be released as his case was "a joke". At 12.59pm, after collecting his lunch, Mr Green went to his cell and the officer locked the cell door.

53. Mr Green's ACCT observation record shows that at 1.00pm, Officer Y noted that Mr Green "has been at healthcare past 2 hours, no reported issues and collected dinner".

54. At 1.08pm, the officer noted in Mr Green's NOMIS record that he had attended the video link and had caused no issues.

55. At 1.45pm, Officer Y checked on Mr Green and found him hanging from a ligature in front of his bunk bed. Officer Y shouted for staff assistance, then called a code blue emergency (which indicates that a prisoner is unconscious or having difficulty breathing). Officer Y entered Mr Green's cell by himself, tried to

support his body and cut the ligature, which was made from a bed sheet. After Officer Y cut the ligature, Mr Green fell to the floor and banged his head on a pipe or the floor.

56. Four officers responded to the code blue emergency and they started cardiopulmonary resuscitation (CPR). An officer collected the defibrillator.

57. The primary care clinical lead, a DART clinical lead, a primary care team lead, and other healthcare staff quickly responded to the code blue emergency. The l DART clinical lead noted Mr Green's head injury as he was bleeding on the back of his head, and the primary care clinical lead asked the officers to move him onto the landing. They inserted an airway, gave Mr Green oxygen and attached a defibrillator (which did not detect a shockable heart rhythm and advised to continue CPR).

58. According to the North East Ambulance Service, the prison made two telephone requests for an ambulance at 1.47pm and 1.49pm. During the first call, an operational support grade (OSG), gave basic information and the Ambulance Service gave it a category 2 response (for a serious condition that may require rapid assessment and/or urgent transport, with an average response time of 18 minutes). During the second call, the OSG said that Mr Green was not breathing so the Ambulance Service upgraded it to a category 1 response (an immediate response to a life-threatening condition, with an average response time of seven minutes).

59. They sent three ambulances to the prison and they reached Mr Green at 1.55pm, 1.58pm and 2.09pm respectively. Paramedics took over the resuscitation attempt, inserted an endotracheal tube and gave Mr Green five doses of adrenaline. They were unable to resuscitate him and, at 2.23pm, a paramedic declared that he had died.

60. At 2.27pm, an operational manager completed a Silver Command Incident Management Decision Report and wrote "Officer Y did not put anything in ACCT."

61. Mr Green left a note in his cell to a friend, which said, "My head's done in pal, I hear her voice all the time asking where I am going and to go with her so I am going to go with her. I've had enough of the shit pal."

### Contact with Mr Green's family

62. Following Mr Green's death, the prison appointed the Managing Chaplain, as the prison's family liaison officer (FLO). At 3.40pm on 21 July, the FLO telephoned Mr Green's mother to break the news of his death and to offer his condolences and support.

63. The FLO continued to support Mr Green's mother and helped to arrange his funeral, which was held on 3 August. The prison paid for the costs of the funeral in line with national instructions.

## Support for prisoners and staff

64. After Mr Green's death, the operational manager debriefed most of the prison and healthcare 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.

65. The prison posted notices informing other prisoners of Mr Green'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 Green's death.

## Post-mortem report

66. The post-mortem examination found that the cause of Mr Green's death was pressure on the neck due to hanging. It also found that he had a superficial cut on the right side of his head.

# Findings

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

*Reception*

67. PSI 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*, provides a non-exhaustive list of risk factors and potential triggers that might increase a prisoner's risk of suicide and self-harm. The PSI sets out the procedures (known as ACCT) that staff should follow when they identify that a prisoner is at risk of suicide and self-harm.

68. PSI 07/2015, *Early Days in Custody*, sets out the processes that should be followed when a prisoner first arrives in prison. This includes that staff should assess a prisoner's risk to themselves by examining all available documentation, including the PER and SASH forms.

69. Mr Green had several risk factors for suicide and self-harm, which included being charged with the murder of his partner, a history of depression and two recent acts of self-harm.

70. When Mr Green arrived at Durham on 20 July, his SASH form recorded that his two acts of self-harm took place in the last month. Despite this information and answers that Mr Green gave during the reception interview, SO X decided not to open an ACCT and relied on Mr Green's statements that he had no thoughts of suicide or self-harm and her perception that he interacted well.

71. We also note that on the Vulnerabilities Assessment, SO X did not classify Mr Green's acts of self-harm in the last month as 'recent', so she was not automatically required to open an ACCT. SO X told the investigator that there were no guidelines to define 'recent' and that she could not recall that the SASH form recorded Mr Green's acts of self-harm within the last month. Given the information available about Mr Green's risks, we consider that not opening an ACCT was an error of judgement.

72. Mr Green saw an officer and a nurse later that evening on E Wing and the mental health clinical lead the following morning. When interviewed, the officer, the nurse and mental health clinical lead all said they had not seen Mr Green's SASH and PER forms. While we appreciate that Mr Green's induction interview, initial health assessment and mental health triage took place on E Wing rather than in reception, we are very concerned that the three members of staff did not have access to the vital information contained in his SASH and PER forms.

73. In our Learning Lessons Bulletin, *Early Days and Weeks in Custody*, published in February 2016, we identified that too often reception staff make decisions based on a prisoner's presentation and their statements that they do not have any thoughts of suicide or self-harm, rather than relying upon known risk factors, such as recent acts of self-harm, the nature of the offence and recent court appearances. Mr Green's case is an example of this: staff relied on his assertions that he had no thoughts of suicide and considered that he did not present as suicidal, and yet 18 hours after he arrived at Durham, he was found hanged in his cell. If staff had taken his risk factors for suicide into account, they

may have recognised that Mr Green was at high risk of suicide and taken action to support and monitor him.

74. Although Mr Green was being monitored under ACCT when he died, we are concerned that that there was a missed opportunity to support him as soon as he arrived at the prison. We are very concerned that this is the fifth time in two years that we have identified similar failings. We make the following recommendation:

**The Governor should ensure that staff manage newly arrived prisoners in line with national guidelines, including ensuring that they:**

- **assess all prisoners arriving in reception and check all accompanying documents to identify any immediate needs and risks;**
- **provide all accompanying documents for any interviews or assessments taking place outside reception; and**
- **base their assessment of a prisoner's risk of suicide and self-harm on the prisoner's known risk factors rather than their presentation or what they say.**

**The Governor should share a copy of this report with SO X and ensure that a senior manager discusses the Ombudsman's findings with her.**

75. We also repeat the recommendation we made in December 2020 following another investigation into a self-inflicted death at Durham:

**The Prisons Group Director for Tees and Wear should write personally to the Ombudsman setting out what he is doing to ensure that staff at Durham have a better understanding of the principles of risk assessment for suicide and self-harm.**

*ACCT management*

76. PSI 64/2011 sets out the processes that should be followed when an ACCT has been opened. This includes that a manager must talk to the prisoner and complete an Immediate Action Plan within an hour of the ACCT being opened, that the ACCT plan must travel to and from any location the prisoner moves to and that staff must follow the planned frequency of observations. It also says that all staff in contact with prisoners must receive ACCT training.

77. An SO opened an ACCT for Mr Green at 11.20am, while he was in the video link department for a court appearance. Although an officer told a another officer that Mr Green had been put on an ACCT, there is no record that a manager spoke to him within an hour of it being opened or once he had returned to E Wing, that the ACCT plan was taken to the video link department or that any formal observations were made on an hourly basis. We are concerned that these failures meant that Mr Green did not receive any formal support before his death, despite being on an ACCT for over two hours before he died.

78. We are also concerned that, during the interviews with a non-clinical DART support worker, a healthcare support worker and a clinical DART support worker, they said that they had not received any ACCT training, though the non-clinical

DART support worker said that an officer briefly covered the ACCT document during some training and the healthcare support worker said other people showed her how to open an ACCT. We are concerned that the non-clinical DART support worker, the healthcare support worker and the clinical DART support worker have not received formal ACCT training, despite having regular contact with prisoners, including newly arrived prisoners who are potentially at greater risk of suicide and self-harm.

79. We make the following recommendation:

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

- **a prison manager talks to a prisoner within an hour of the ACCT being opened;**
- **the ACCT plan follows the prisoner around the establishment;**
- **staff adhere to the frequency of observations set out in the ACCT document; and**
- **staff in contact with prisoners receive appropriate ACCT training.**

*ACCT observation record*

80. Mr Green's ACCT observation record shows an entry by Officer Y at 1.00pm, that Mr Green "has been at healthcare past 2 hours, no reported issues and collected dinner". However, at 2.27pm, an operational manager wrote in the Silver Commander Incident Management Decision Record that "Officer Y did not put anything in ACCT".

81. Officer Y told the investigator that he was "definitely sure" that he wrote an entry in Mr Green's ACCT and that he could not explain why someone had told the operational manager that he had not done so. Officer Y also said that he could not remember why he wrote that Mr Green had been in healthcare, rather than in the video link department, and thought he had overheard someone say this. However, another officer told the investigator that he specifically told Officer Y that he had returned Mr Green from the video link.

82. The operational manager told the investigator that the information in the Decision Record had been supplied by someone on E Wing and, at that time, she had not seen Mr Green's ACCT to check for herself. She said that when she saw the ACCT, sometime later, she noted that Officer Y had written an entry in the observation record. She also said that she would be surprised if Officer Y had added an entry retrospectively to Mr Green's ACCT and described him as "a very good officer, very thorough".

83. We do not consider there is sufficient evidence to suggest that Officer Y wrote his ACCT entry retrospectively.

## Substance misuse care

84. As part of Mr Green's substance misuse monitoring, two episodes of miscommunication took place on 21 July. The first took place when the clinical

DART support worker gave incorrect information about the severity of Mr Green's alcohol withdrawal to the clinical lead for the Remote and Agile service, who created a treatment plan based on that information. The second took place after the clinical lead for the Remote and Agile service asked healthcare staff to check Mr Green's blood sugar level, using the outdated abbreviation BM, and the healthcare support worker checked Mr Green's blood pressure, commonly abbreviated to BP. As the clinical DART support worker and the healthcare support worker quickly realised their mistakes and no harm had come to Mr Green or his cellmate, the clinical reviewer concluded that these events were due to human errors. The clinical reviewer was satisfied that these communication issues had been recognised at all levels in the healthcare department and that no recommendations were required.

85. Overall, the clinical reviewer concluded that the substance misuse care that Mr Green received was equivalent to that which he could have expected to receive in the community.

## Emergency response

### *Mr Green's head injury*

86. We commend Officer Y for entering the cell promptly and cutting the ligature when he found Mr Green hanging. Mr Green fell to the floor and hit his head. Officer Y told the investigator that his "first instinct is, get that [the ligature] off his neck" and "he's either hit it off the pipes or hit it off the floor… I'm paying attention to the ligature, nothing else".

87. We note that Officer Y was alone when he found Mr Green and that it would have been very difficult for him to cut the ligature and support Mr Green's body by himself. While it is regrettable that Mr Green suffered a head injury after he was cut down, we note that the pathologist described it as a "superficial laceration". We consider that Officer Y made the correct decision in immediately cutting the ligature and removing the pressure on Mr Green's neck.

### *Ambulance call*

88. PSI 03/2013, *Medical Emergency Response Codes*, says that prison staff must use emergency codes to clearly convey the nature of the medical emergency and that when a medical emergency code is called over the radio, control room staff must call an ambulance immediately. Durham's Medical Emergency Response Codes protocol reflects the content of PSI 03/2013.

89. In March 2017, HMPPS and the Association of Ambulance Chief Executives agreed national guidelines to ensure that prisoners receive high quality emergency medical care. These guidelines say that the member of prison staff who discovers a medical emergency should provide the prison's control room with relevant information, including whether the patient is conscious and whether they are breathing, as these questions will be asked by the ambulance call handler. While these guidelines apply to all prisons in England and Wales, they are not referred to in PSI 03/2013 or in Durham's local protocol on Medical Emergency Response Codes.

90. Officer Y called a code blue at 1.45pm. Two minutes later, an OSG called for an ambulance and gave basic information about Mr Green's condition, based on the fact that an officer had called a code blue. However, due to delays in passing more detailed information about Mr Green's condition from the scene to the control room, it was not until the OSG's second call at 1.49pm, when the OSG said that Mr Green was not breathing, that the North East Ambulance Service upgraded the incident to a category 1.

91. Although the control room called for an ambulance in response to the code blue, we are concerned that it took a second call, four minutes later, before the Ambulance Service sent the appropriate emergency category of ambulance. The delay was due to the control room's inability to provide sufficient information about Mr Green's condition in the first call. We are concerned that despite the national guidelines agreed between HMPPS and the Association of Ambulance Chief Executives, staff on the scene did not provide the prison's control room with relevant information. We consider that this should be covered in the national instruction on Medical Emergency Response Codes so that all prisons include it in their local protocol. We make the following recommendation:

**The Director General of Prisons should amend Prison Service Instruction 03/2013 to reflect the national guidelines agreed between HMPPS and the Association of Ambulance Chief Executives.**

### Post-incident actions

92. PSI 08/2010, *Post Incident Care*, and PSI 64/2011 set out the actions that should be taken following a death in custody. This includes that all staff involved in an incident must attend a hot debrief and must complete Incident Report Forms as soon as possible. It also says that a prison must retain and securely store all documentation relating to the deceased prisoner, including any evidential telephone recordings.

93. Following Mr Green's death, the operational manager held a hot debrief with numerous prison and healthcare staff. However, despite being listed as an attendee on the hot debrief minutes, an officer told the investigator that she was not invited because she had returned to her own wing.

94. While we appreciate that an officer's absence was unintended and that a care team member personally offered her support, we consider that all staff involved in the emergency response should be invited to attend a debrief before returning to their normal working locations. We also note that only two officers and the primary care clinical lead night completed Incident Report Forms to record their involvement in the emergency response despite numerous other prison and healthcare staff being involved.

95. Following Mr Green's death, the prison noted that he had used his cellmate's telephone account to telephone a friend, as his access was restricted, and they gave the police a copy of the recording. However, the prison failed to keep a recording of this call and failed to provide the investigator with a copy. We are disappointed that we have not been able to listen to Mr Green's call, particularly as the post-mortem report suggests the conversation was a significant one.

96. We make the following recommendations:

**The Governor should ensure that all managers follow the national guidelines for dealing with a death in custody or serious incident, including that:**

- **a debrief is held promptly after the death of a prisoner and that all staff that are involved are invited;**
- **all staff directly involved in an incident should complete Incident Report Forms as soon as possible; and**
- **all documentation, including any evidential telephone recordings, are retained and securely stored.**

## Learning lessons

97. We consider that it is important for managers and staff who were involved in Mr Green's care to see the findings of our investigation. We make the following recommendation:

**The Governor and Head of Healthcare should ensure that any staff named in this report are given the opportunity to read the report at the initial stage in line with paragraph 1.11 of PSI 58/2010.**

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100
F I 020 7633 4141