

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Kevin Rowntree, a prisoner at HMP Holme House, on 16 December 2021

A report by the Prisons and Probation Ombudsman

OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE



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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 Kevin Rowntree was found dead on the floor of his cell at HMP Holme House on 16 December 2021. He had hanged himself from the light fitting. He was 41 years old. I offer my condolences to Mr Rowntree's family and friends.

Mr Rowntree gave no indication to staff that he was at risk of suicide. Although information came to light after Mr Rowntree's death that he was struggling and was considering taking his life, I am satisfied that staff were unaware. I consider that staff at Holme House could not have foreseen Mr Rowntree's actions.

I am concerned, however, that the officer who unlocked Mr Rowntree on the morning of 16 December did not notice that he was dead on the floor and that another prisoner discovered him. There was a lack of clear guidance to staff on how to check prisoners' welfare during the unlock process. This needs to be addressed.

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

July 2022

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Summary

Events

1. On 30 November 2020, Mr Kevin Rowntree was remanded in prison custody, charged with various offences, including robbery, common assault and breach of a non-molestation order. He was sent to HMP Durham.
2. Mr Rowntree had a history of anxiety and depression and was prescribed antidepressant medication. In March 2021, he asked to see someone from the mental health team. However, when an appointment was offered to him, he failed to engage with the support offered.
3. On 4 October, Mr Rowntree was sentenced to six years and six months in prison. On 29 October, he was moved to HMP Holme House. Reception staff noted that he had a history of anxiety and depression and a prison GP prescribed his antidepressant medication. Mr Rowntree declined input from the mental health team and no further concerns were noted.
4. Mr Rowntree had three sessions with his allocated keyworker on 12 November, 27 November and 14 December. His keyworker noted that he did not seem to want to engage with her but she had no concerns about him.
5. At around 4.40am on 16 December, an operational support grade (OSG) looked into Mr Rowntree's cell as part of the standard morning roll check. He saw nothing of concern. At approximately 8.52am, an officer unlocked Mr Rowntree's cell but she did not look in. Around a minute later, a prisoner alerted the officer that Mr Rowntree was lying on the floor of his cell.
6. The officer called an emergency code blue, an ambulance was called and healthcare staff attended. However, staff quickly realised that Mr Rowntree had been dead for some time. He had hanged himself from the light fitting. Staff therefore did not continue with attempts to resuscitate him. Ambulance paramedics confirmed Mr Rowntree's death at approximately 9.15am.
7. Mr Rowntree left a suicide note which said that his mental health was at its worst and he could no longer cope. After Mr Rowntree's death, a prisoner told staff that Mr Rowntree had said he was going to kill himself because he was worried that it had got out that he had been accused of mugging a pensioner.

Findings

8. We are satisfied that Mr Rowntree gave no indication to staff that he was at risk of suicide and that they could not have foreseen his actions. Although information came to light after Mr Rowntree's death that he had been struggling with his mental health, we are satisfied that staff were unaware of this.
9. We are satisfied that the morning roll check was carried out properly and that the night OSG saw nothing of concern. However, we are concerned that the officer who unlocked Mr Rowntree's cell four hours later did not notice that he was dead on the floor.

10. We found that there was no clear unlock guidance in place at the prison at the time of Mr Rowntree's death. The officer who unlocked Mr Rowntree should have tried to get a verbal response from him and then she would have realised that he was unresponsive on the floor. It was unacceptable that another prisoner discovered him.
11. The clinical reviewer concluded that Mr Rowntree's clinical care was equivalent to that which he could have expected to receive in the community.

Recommendations

- The Governor should ensure that, in line with PSI 75/2011, staff are issued with clear guidance on how to check on the welfare of prisoners when unlocking cells.

The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Holme House informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
13. The investigator obtained copies of relevant extracts from Mr Rowntree's prison and medical records.
14. NHS England commissioned an independent clinical reviewer to review Mr Rowntree's clinical care at the prison. The investigator and clinical reviewer interviewed three members of Holme House staff on 23 February and 8 March 2022. The interviews were conducted by telephone because of the restrictions in place during the COVID-19 pandemic.
15. We informed HM Coroner for Teesside of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
16. We wrote to Mr Rowntree's nominated next of kin, his mother, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Rowntree's family wanted to know:
 - How long was he dead before he was found?
 - What medication was he prescribed?
 - Was he on suicide watch?
 - What mental health support did he get?
 - Had the police told him he would be charged?
 - Is there any evidence of why he would take his own life?

We have answered the family's questions in this report.

17. We shared our initial report with Mr Rowntree's mother who identified a factual inaccuracy on the clinical review which has been amended. Mr Rowntree's mother raised other issues which did not affect the factual accuracy of the report and these have been addressed in separate correspondence.
18. We shared our initial report with the Prison Service. The Prison service pointed out some factual inaccuracies with our report and the clinical review which have been amended. The action plan has been annexed to this report.

Background Information

19. HMP Holme House HMP Holme House is a category C training and resettlement prison holding a maximum of 1159 men. Spectrum provides health services at the prison. There is a 24-hour healthcare unit with 16 beds.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Holme House was in February and March 2020. Inspectors reported that the prison was not sufficiently good in a number of areas, including prisoner safety, although they acknowledged that the safer custody team had undertaken some recent work to improve the quality of the ACCT case management process. Incidents of self-harm had doubled since the last inspection in 2017 and there had been three further self-inflicted deaths. Positively, inspectors reported that all prisoners now had an allocated keyworker and 67% of prisoners found them to be helpful. Mental health services were good and delivered responsive, evidence-based treatments.

Independent Monitoring Board

21. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year ending 31 December 2020, the IMB reported that staff referred 638 prisoners for ACCT monitoring during 2020. This was significantly higher than in 2019. Inspectors reported that incidences of self-harm had increased significantly, particularly in the second half of their reporting year. Despite the challenges, prisoners who self-referred to the mental health team were seen within four to five days with urgent cases being seen within 24 hours. There was no waiting list for GP services and prisoners received an overall responsive service.

Previous deaths at HMP Holme House

22. Mr Rowntree was the 13th prisoner to die at Holme House since December 2019. Of the previous deaths, eight were from natural causes, two were self-inflicted, and two are awaiting classification. There are no similarities between our findings from our investigation into Mr Rowntree's death and our investigation findings from the previous deaths.

Key Events

23. On 30 November 2020, Mr Kevin Rowntree was remanded in prison custody charged with various offences, including robbery, common assault and breach of a non-molestation order. He was sent to HMP Durham. Mr Rowntree had been in prison many times before and had last been released in September 2020.
24. A nurse carried out a reception healthcare screening and noted that Mr Rowntree had a history of anxiety and depression for which he was prescribed an antidepressant (mirtazapine). She noted that he had no current thoughts of suicide or self-harm and he declined any input from the mental health team. Although he said he used cannabis occasionally and had a previous history of alcohol misuse, Mr Rowntree declined any intervention from the substance misuse service. The nurse referred Mr Rowntree to the prison GP who prescribed mirtazapine.
25. On 3 March 2021, Mr Rowntree told a nurse that he needed support from the mental health team. He said he was low in mood because of problems in the community with his partner and children. He told the nurse that he did not feel suicidal at that time, but that he had tried to hang himself in his cell the previous November. This information was not known to staff at the time. The nurse passed his referral to the primary care mental health team (Rethink) so that he could be assessed for low intensity cognitive behavioural therapy. Rethink sent him an introductory letter and placed him on the waiting list for assessment.
26. On 31 March, Mr Rowntree failed to attend his appointment with Rethink. Staff discussed his case the following day at a multi-disciplinary team meeting and he was offered a further appointment with them on 1 April. However, he declined to engage with the support on offer. Mr Rowntree did not report any further mental health concerns while at Durham and there were no concerns about his wellbeing.
27. In August, Mr Rowntree was interviewed by police as part of their investigation into further alleged burglary offences. He was not charged with any further offences.
28. On 4 October, Mr Rowntree was sentenced to six years and six months in prison. On 29 October, he was moved to HMP Holme House. At his healthcare reception screening, the nurse noted that he had a history of anxiety and depression for which he was prescribed mirtazapine. She noted that he had no current thoughts of suicide and self-harm and that he engaged well throughout the assessment. In line with standard COVID-19 procedures at the time, Mr Rowntree was located on the Reverse Cohorting Unit (RCU – where newly arrived prisoners are kept separate from the main prison for at least 14 days to limit the spread of COVID-19).
29. On 1 November, a prison GP prescribed a further supply of mirtazapine as well as pain relief (celecoxib) for Mr Rowntree's ongoing shoulder pain.
30. On 12 November, Mr Rowntree had his first keyworker session with his allocated keyworker. He told his keyworker that he was fine and had no concerns with the regime. He said he was hoping to move onto the main prison wing soon.
31. On 13 November, Mr Rowntree was moved from the RCU to a single-occupancy cell on House Block 2.

32. On 27 November, Mr Rowntree's keyworker went to see him for his second keyworker session. She noted in his record that he was asleep in his cell and, although she tried to talk to him, he did not want to engage in conversation. She said she would come back and see him another time.
33. On 14 December, Mr Rowntree was moved to a different cell on House Block 2. His keyworker saw him for a keyworker session on the same day. She noted in his record that he said he was fine and he was settled on House Block 2. He said he did not have anything to discuss with her but he knew how to contact her if he needed to.
34. Mr Rowntree's keyworker told the investigator that she had no concerns about Mr Rowntree when she met him for keyworker sessions. She said that he was not particularly talkative and did not seem to want to engage with her but this was not a worry for her. She said she would have flagged up concerns if she had any.
35. On the morning of 15 December, a prison GP saw Mr Rowntree as he was complaining of ongoing shoulder pain. Mr Rowntree told the GP that previous pain relief medication had negative side effects so the GP prescribed naproxen at his request. The GP told him she would make a referral for further investigation at the hospital.

Events of 16 December 2021

36. At around 4.40am on 16 December, an operational support grade (OSG) looked into Mr Rowntree's cell as part of the standard morning roll check. The OSG could not specifically recall what he saw when he looked into Mr Rowntree's cell but he told the investigator he would at least have had a visual sighting of him. He was confident that he checked all cells and that nothing was out of the ordinary, otherwise he would have taken appropriate action.
37. At approximately 8.52am, an officer unlocked Mr Rowntree's cell for morning association. CCTV shows her opening the cell door but she does not look into the cell. The officer told the investigator that she was aware of the need to get a visual sighting or verbal response from prisoners at unlock. However, she said she would give them time to wake up properly before going back to check on them if she did not see them within a few minutes of unlock.
38. Almost immediately after the officer unlocked Mr Rowntree's cell, a prisoner went into the cell and saw Mr Rowntree lying on the floor. The prisoner came out of the cell and shouted for the officer. CCTV shows she returned to the cell at 8.53am and immediately called an emergency code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties) as she found Mr Rowntree was cold to the touch with no pulse.
39. A nurse responded immediately to the emergency code blue and arrived at 8.56am. She did not have an emergency bag with her as she was not the designated first responder, but she attended as she was nearby. She said she could see signs that Mr Rowntree had attached a ligature from the light fitting. She initially tried to carry out chest compressions on him but soon realised there were signs of rigor mortis (stiffening of the body that occurs two to six hours after death) and therefore further attempts to resuscitate him would be futile. Another nurse arrived shortly afterwards

with the emergency bag but the first nurse indicated to her that no further intervention was necessary as Mr Rowntree was already dead. Paramedics arrived shortly afterwards and confirmed Mr Rowntree's death at approximately 9.15am.

Information received after Mr Rowntree's death

40. Mr Rowntree left a suicide note in his cell addressed to his mother and his partner. He said his mental health was at its worst and he could no longer cope. He apologised to them and other family members, including his daughter, son and sister, and asked everyone to have a party at his funeral.
41. After Mr Rowntree's death, two prisoners said they had had concerns about him. One said that he had smelt of alcohol on the night before he died. The other said Mr Rowntree told him he was going to kill himself as he was worried it had got out that he had been accused of mugging a pensioner. This information was not shared with staff before Mr Rowntree took his life.
42. The police confirmed that Mr Rowntree had not been charged with any additional offences at the time of his death.

Contact with Mr Rowntree's family

43. The prison appointed a prison manager and an officer as the family liaison officers and identified Mr Rowntree's mother as his next of kin. At 10.45am, they visited Mr Rowntree's mother at her home and broke the news of his death.
44. The prison contributed towards the cost of Mr Rowntree's funeral in line with Prison Service guidance.

Support for prisoners and staff

45. A prison manager held a debrief on the day of Mr Rowntree's death to offer support to the staff involved in the emergency response and to ensure they had the opportunity to discuss any issues. The staff care team also offered support
46. The prison posted notices informing other prisoners of Mr Rowntree'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 Rowntree's death.

Post-mortem report

47. The pathologist concluded that Mr Rowntree died as a result of asphyxiation due to hanging. The toxicology report is still awaited.

Findings

Management of Mr Rowntree's risk of suicide and self-harm

48. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*, requires all staff who have contact with prisoners to be aware of the triggers and risk factors that might increase the risk of suicide and self-harm, and take appropriate action. PSI 64/2011 sets out the procedures (known as ACCT) that staff must follow if they identify a prisoner at increased risk. We found that appropriate measures were taken by staff at both Durham and Holme House to explore potential risk factors and offer appropriate support. Mr Rowntree was prescribed medication for depression and anxiety and informed of support available if needed for mental health and substance misuse.
49. Mr Rowntree was not monitored under ACCT procedures at either Durham or Holme House. We accept that Mr Rowntree gave no indication that he was at risk of suicide and self-harm and therefore there was no reason to start ACCT monitoring. Although information came to light after Mr Rowntree's death that he was struggling with his mental health, we are satisfied that this information was not known to staff at the time. We make no recommendation.

Morning unlock

50. An OSG carried out the early morning roll check at around 4.40am on 16 December. CCTV shows that he shone a torch through the observation panel to look into Mr Rowntree's cell. He could not remember exactly what he saw when he looked into the cell but he told the investigator he was confident that there was nothing of concern or he would have raised the alarm. We are satisfied that the OSG carried out a proper check. It appears likely that Mr Rowntree hanged himself a short time later. Mr Rowntree had rigor mortis when he was found, which indicates that he had been dead for at least two hours at 8.52am.
51. We are concerned about the lack of a welfare check when Mr Rowntree was unlocked on the morning of 16 December. CCTV shows that the officer just unlocked the door and did not look into Mr Rowntree's cell. She told the investigator that she would have gone back and checked on him if she had not seen him after a few minutes of opening the door. We accept that Mr Rowntree was already dead by that time and a welfare check at that point would not have saved his life. However, the officer's failure to check that he was safe and well when she unlocked the cell meant that another prisoner found Mr Rowntree dead. This is unacceptable.
52. Prison Service Instruction (PSI) 75/2011, *Residential Services*, notes that it is unacceptable for staff unlocking a prisoner in the morning not to notice that the prisoner has died overnight. It says, 'The appropriate arrangements depend on the local regime, but there need to be clearly understood systems in place for staff to assure themselves of the wellbeing of prisoners during or shortly after unlock. For example, if a prisoner is expected to leave their cell for an activity shortly after being unlocked, then it will be sufficient for there to be a check on any prisoner who does not do so. Where prisoners are not necessarily expected to leave their cell, staff will

need to check on their wellbeing, for example by obtaining a response during the unlock process.’

53. We found that there was no clear guidance to staff at Holme House about what they should do to check on the welfare of prisoners when unlocking cells. We consider that in the case of Mr Rowntree, the officer should have tried to get a verbal response from him when she unlocked his cell. Had she done so, she would have realised that he was dead on the floor. We are aware that a Governor’s Notice on welfare checks has been issued to staff since Mr Rowntree’s death. Nevertheless, we make the following recommendation:

The Governor should ensure that, in line with PSI 75/2011, staff are issued with clear guidance on how to check on the welfare of prisoners when unlocking cells.

Clinical care

54. The clinical reviewer concluded that Mr Rowntree’s mental and physical healthcare was of a good standard and at least equivalent to that which he could have expected to receive in the community.
55. Although Mr Rowntree mentioned in a suicide note to his family that his mental health was very poor, we found no evidence that staff were aware of any issues with his emotional wellbeing. The only time he requested help from the mental health team was in March 2021 at Durham. We found that staff responded appropriately to his request for support but he unfortunately did not engage with the support on offer. He did not request support for his mental health at any time at Holme House and no concerns were noted.
56. We consider that the decision by nurses to stop resuscitation attempts on Mr Rowntree was appropriate given he was clearly dead when he was found.

Inquest

57. The inquest, held on 27 and 28 November 2023, concluded that Mr Rowntree died by suicide.

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

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

T | 020 7633 4100