

**Investigation into the circumstances surrounding the
death of a man at HMP Durham
In May 2009**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

December 2010

This is the report of an investigation into the death of a man. He was found hanging in his cell at HMP Durham in May 2009. At the time of his death he was a remand prisoner having been charged with the murder of his partner in April 2009. He had been in prison less than a month. He was 40 years of age.

I extend my condolences and those of my colleagues to the man's family. I hope that my report goes some way to answering any questions they may have. I apologise for the delay in completing this report.

The investigation was carried out on behalf of the Ombudsman by one of her investigators. A clinical review was commissioned from the local Primary Care Trust (PCT) into the medical care that the man received whilst in prison custody. An initial review was completed in November 2009. However, the PCT commissioned a second review as they judged that the first had not adequately addressed all the relevant issues. A clinical reviewer was commissioned to complete a second review. I am grateful to her.

I would also like to take this opportunity to thank all of the staff at Durham and HMP Holme House for their cooperation during the investigation. In particular I am grateful to the liaison officer for his assistance to the investigator. This is the ninth apparently self inflicted death to have taken place at Durham since the Ombudsman started investigating such deaths in April 2004.

It is evident from the investigation that the man was a quiet man who, although mixing with others, kept much to his own company. Although he told staff he was fine and expressed no concerns, it is evident from the conversations that he had with his parents that this was not the case. Although he had no clinical history of mental illness or self harm, he had, shortly before his arrest attempted to take his own life and was admitted to hospital under the Mental Health Act. However, despite this and having received information from several outside sources about his risk of suicide and self harm, the clinical reviewer concludes that mental health assessments completed by staff were inadequate and insufficient. Not only had he harmed himself recently, but he had been formally admitted to a psychiatric hospital and, most significantly, was charged with a violent offence against his partner. All three factors raised the risk that he would harm himself again. I make a recommendation with regard to these failures and also several relating to the Assessment, Care in Custody and Teamwork procedures which were opened at Holme House and continued on his transfer to Durham.

Although the man's personal circumstances placed him at high risk of harming himself, his general demeanour in the time leading to his death was in stark contrast to the expressions of intent that he conveyed to his parents in several telephone conversations. However, I concur with the clinical reviewer in believing that staff could not have reasonably predicted or ultimately prevented his death.

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

Jane Webb
Acting Prison and Probation Ombudsman

December 2010

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SUMMARY

The man was admitted to hospital under the Mental Health Act on 15 April 2009, after being found on a local railway line where he apparently intended taking his own life. He discharged himself on 20 April. He was charged with the murder of his partner on 21 April, and admitted to hospital for the treatment of wounds he had inflicted upon himself at the time of the offence, before being released into police custody on 23 April.

On 27 April, he was remanded into custody at HMP Holme House. A letter that accompanied him, written by the police doctor, advised that he was at high risk of harming himself and had a "... manipulative, narcissistic personality". A Suicide Self Harm Warning Form was also raised by Global Solutions Limited (GSL). (GSL provide prison escort services on behalf of the Prison Service.) A memorandum written by North Yorkshire Police, also strongly recommended that he should be continuously observed in custody and placed on the highest category of suicide watch if remanded into prison.

When the man arrived at Holme House the reception officer initiated Assessment, Care in Custody and Teamwork (ACCT) procedures. (ACCT procedures are used by the Prison Service to assess, observe and support prisoners at risk of harming themselves.) The officer noted on the ACCT that he had made previous attempts to harm himself and had been observed continuously whilst in police custody. The officer also discussed his situation with the reception nurse, informing her of the paper work that had accompanied him. Whilst in reception a number of other prison documents were completed and he was given a first night reception health screen by one of the nurses. The nurse noted that he was considered to be at high risk of harming himself, but was not aware that he had been under continual observation in police custody.

As part of the ACCT process, staff agreed an immediate action plan for him. They noted that he should be moved to the healthcare unit and placed in a camera cell, and that a good quality conversation should be made with him at least four times every 24 hours. An ACCT review took place the following day, 28 April, and he told staff that he had no thoughts of harming himself.

Due to a potential security compromise, the decision was taken for him to be transferred to HMP Durham later that day. On his arrival at Durham, he was located in the healthcare unit and assessed by a nurse who made a verbal referral to the mental health in reach team (MHIRT). He was given a brief induction on prison life and he was described by staff as quiet, polite and friendly. An informal review of his ACCT document was undertaken and no significant concerns were identified.

Over the following days the man was reported to have settled at Durham, mixing with other prisoners and attending association and other activities. During this time he expressed no thoughts of harming himself to staff. However, in a telephone call to his mother on 1 May, he told her that he wanted to "top himself" and complained of having no money or cigarettes. At an ACCT review later that day, he told staff that he did not feel at risk of harming himself or had any suicidal ideas. The following days saw him apparently continue to settle into prison life. But, in another telephone

conversation to his mother, on 4 May, he repeated that he was depressed and felt like killing himself.

A further ACCT review took place on 6 May. He told the review panel that he was fed up. He said that, although he had no thoughts of harming himself at that time, he could give no guarantees about the future. He was advised of the support around him if he should think any more about harming himself.

During his time at Durham, the man became on occasions upset and agitated when his tobacco ran out, but he did not express any other concerns to staff. Over the following days notes in his prison record continued to report that he had become more settled. He took part in education, exercise and association. However, he again told his parents on 10 May that he wanted to “top himself” and that he would find a way of doing so.

His final ACCT review took place on 12 May. The reviewing staff noted that he had said that he did not have any more thoughts of harming himself and so they concluded that the ACCT procedures could be closed. One of the mental health nurses noted how far he had come, that he was bright and seemed to be coping with his situation.

Over the following days he spoke with his family, telling them that he was fed up. However, entries made by staff in his records continued to reflect the apparent progress he had made and expressed no further issues or concerns.

On the morning of 16 May, the man collected his breakfast as usual. Staff said that there was nothing in his behaviour which indicated his intent to harm himself. At around midday, after morning association, he collected his lunch before returning to his single cell. At 2.14pm a member of staff found him hanging and the alarm was raised. Healthcare staff attended and resuscitation was attempted. However, this was not successful and, despite a continued effort by paramedics, he was pronounced dead on arrival at hospital.

My report makes a number of recommendations, the most significant of which relate to delays referring the man for an assessment by the MHIRT. I also draw attention in my report to concerns about the quality of ACCT procedures, sharing information and delays in calling an ambulance.

THE INVESTIGATION PROCESS

1. The investigation following the man's death was carried out by one of my investigators. Another of my investigators opened the investigation on 21 May 2009 when he visited HMP Durham. He met the Acting Governor of Durham, the Head of Business and Performance, the Head of Safety and Decency and a number of other senior managers at the prison. He also met a representative from the Prison Officers' Association and a member of the Independent Monitoring Board (IMB). (IMB members are independent and unpaid. They monitor day-to-day life in the prison to ensure that proper standards of care and decency are maintained.)
2. Notices announcing the investigation and its terms of reference were issued to both staff and prisoners at Durham. The notices were displayed around the prison and invited staff and prisoners to contact my investigator should they wish to do so. Unfortunately the investigator was unable to speak with the prisoners located in adjacent cells to the man's at the time of his death. One had been discharged to a psychiatric hospital and the other had been released on bail.
3. He obtained documentation relating to the time that the man spent at Durham and visited the prison on several occasions to interview staff and prisoners. My investigator also had access to transcripts of telephone calls made by him to members of his family. (The content of these telephone calls were not known to staff before his death. Only a small percentage of telephone calls made by prisoners are monitored. When calls are monitored they are usually for reasons of security or child protection. He did not fall into these categories.)
4. Due to the fact that the man had only recently been transferred from HMP Holme House, the investigator also visited Holme House to interview staff. I would like to thank the Head of Safety and Decency at Holme House for her assistance to the investigator both during his visit and subsequently when he requested additional information. During the course of the investigation he provided verbal and written feedback to both the Governor at Durham and the Governor of Holme House.
5. A clinical review was commissioned from the local Primary Care Trust (PCT). An initial clinical review was completed in November 2009. However, the PCT commissioned a second review as they thought that the first review had not adequately addressed all of the relevant issues. The clinical reviewer completed the second review on their behalf. I would like to thank her for her assistance.
6. One of my family liaison officers contacted the man's parents to discuss the purpose and scope of the investigation and give them the opportunity to raise any questions or concerns they had about his death. His parents enquired as to whether their son had been on a "suicide watch". They asked whether his telephone calls were monitored as, on several occasions, he had told his mother that he was intending to kill himself. They also asked why prison staff had not contacted them during his stay, as they knew so much about his condition.

7. I hope that this report helps address the family's concerns and any other issues that remain unclear, helping them to better understand what happened to their son in the time leading to his death.

In their response to the draft report the man's parents made the following comments. I draw these to the attention of the Prison Service and Primary Care Trust. The man's father says:

"From the report, it is obvious that certain procedures were flawed, clearly identified in some instances by the lack of any cohesive inter-departmental information audit trail. It is not entirely clear if information pertaining to my son's treatment under the mental health act was available to the prison authorities.

I note that the recommendations cover a list of identified shortfalls in procedures. Whilst the recommendations advise governors to ensure systems are in place to improve procedures, there is no mention of standardising a process that will provide an audit trail if required. Nor is there any timescale to implement improved procedures.

There are however two areas that still concern me, and had they been in place perhaps the outcome may have been different.

1. Outgoing phone calls from pay phones should have a pre-recorded message advising the recipients of general procedures together with a dedicated phone number to ring for passing on concerns regarding the well being of individuals.
 2. An examination of inter agency information flow is in place to ensure a standardised and auditable system for recording relevant information pertaining to individual prisoners."
8. My investigator also spoke with a Detective Sergeant from Durham Constabulary, who is acting on behalf of the coroner. He has also been in contact with the Coroner's office and a copy of this report will be sent to HM Coroner for the North and South districts of Durham and Darlington to assist his enquiries. A copy of this report will also be sent to the National Offender Management Service, the organisation that oversees the Prison Service.

HMP DURHAM

9. HMP Durham is a Category B local prison built in the early 19th Century. It serves courts in the north east of England and it holds just under 1,000 prisoners. The prison consists of seven wings as well as a segregation and healthcare unit.
10. The last full inspection of Durham, by Her Majesty's Chief Inspector of Prisons, was in September 2006. She reported that overall Durham was an improving establishment which was developing its new role as a local and community prison serving the north east. She added that there was clear and focussed management and considerable goodwill from staff. However, she identified that some ACCT support plans reviewed were inconsistent and incomplete.
11. In their report for the year 2007 to 2008 the Independent Monitoring Board (IMB) referred to the variable quality of ACCT documentation from time to time but despite this the prison was performing well as evidenced by high audit markings.
12. The man's death was the ninth apparently self-inflicted death in Durham since the Ombudsman took on the responsibility for the investigation of deaths in custody in April 2004. Sadly another apparently self-inflicted death in custody occurred at the prison two days after the man's, bringing the total to four deaths within a ten week period. Three of the prisoners who died had been on an ACCT document up to or close to the time of their death. However, there appear to be no other similarities between those deaths and that of the man's.
13. Assessment, Care in Custody and Teamwork (ACCT) procedures are used to assess, observe and support prisoners who are at risk of harming themselves. They highlight problems and possible trigger points of a prisoner at risk of harming himself and make a multidisciplinary plan to give support and help through a period of crisis. Prisoners subject to the ACCT process are observed regularly, depending on the risk that they pose to themselves. These can vary between continuous observation (constant watch), or a specified number of times an hour, again based on risk. Interactions with prisoners are also noted as part of the ACCT procedures.
14. Durham prison operates a confidential hotline for relatives and friends to contact the prison should they have any concerns about a prisoner. The hotline is accessed by dialling the prisons main switchboard and selecting the relevant option. The line enables relatives and friends to leave a message about their concerns. Alternatively should a relative or friend speak to the telephone operator at the prison, expressing concern about a prisoner, their call will be forwarded directly to staff in the safer custody unit.

KEY EVENTS

15. On 15 April 2009, the man was found lying on a railway line. It appeared that he intended to kill himself. He was compulsorily admitted to hospital under the Mental Health Act, where he remained until discharging himself on 20 April.
16. During an attack on his partner on 21 April, he wounded himself by making multiple cuts to his hands and forearms. He was treated for his injuries at hospital. He was subsequently charged with the murder of his partner.
17. The man was discharged from hospital into police custody on 23 April and transferred to a police station. The hospital doctor noted on the hospital discharge summary that his stitches would need to be removed in two weeks time. She also said that he “Needs suicide watch and follow up by prison in-reach psychiatrics”.
18. In a letter dated 27 April, and addressed to the “healthcare staff and carers” of the man, a doctor, who had attended to him whilst he was in police custody, provided details of his recent medical history. (The letter was filed in the man’s prison medical records.) The doctor wrote that he was of low mood, had declined antidepressants, was at high risk of harming himself and had been on a constant watch. (Constant watch is a police and Prison Service term for someone who is being observed continuously by staff because they are at serious risk of harming themselves.) The doctor provided details about other medical matters including his prescription of painkillers and antibiotics and his medical needs as a consequence of the injuries he had made to his wrists and forearms. The doctor added that, in his opinion, he had a “... manipulative, narcissistic personality” and would require a psychiatric follow up in prison.
19. At 9.00am on 27 April, Prisoner Custody Officer (PCO) A, the GSL prisoner escort officer, completed a Suicide Self Harm Warning Form when collecting the man for his transfer from the police station to the Magistrates Court. (A Suicide Self Harm Warning Form is used by court and prisoner escort staff to warn Prison Service staff of a prisoner’s heightened risk of harming himself.) In response to information received from a Police Sergeant, the PCO wrote on the form that he had made “... very deep cuts to each wrist, he also laid on a railway track in a failed attempt to harm himself”. She noted that, although he seemed calm and was talkative, he was deemed a “high risk”. He was observed continuously during the escort and at court. Later that morning he was remanded into prison custody at HMP Holme House.
20. Accompanying the Prisoner Escort Record (PER form – a document used by escort staff to record a prisoner’s known risks and other information) was a memorandum from a Sergeant, the custody sergeant at the police station. The memorandum entitled, GSL Further Information (police memo to GSL), and which had been given a marker of “Very Important”, was also received by Holme House reception staff on 27 April. (Although the document appears to have been prepared on 26 April.) The police memo to GSL advised that the man had serious hand and wrist injuries, had been calm and subdued in police custody and had not threatened violence and had been constantly supervised whilst in

police custody. The Sergeant wrote:

“Strongly recommend that observation regime continues whilst he is in your custody. He should not in my opinion be unsupervised at any time during his transport and housing at court. He should be placed on the highest category of suicide watch at Prison if remanded and this information should accompany the DP [detained person] at all times and be handed to the relevant authorities.”

21. The PER form that accompanied the man from the police station to court, noted that he required a high level of supervision due to his self harming, and was required to be under constant watch in the court cells. At 11.40am he transferred to Holme House, having been remanded into prison custody until his appearance at Crown Court on 5 May. He was continually observed during the journey, arriving at the prison at 12.15pm. On his arrival PCO B, another of the GSL escort officers, briefed prison staff about the man’s history of suicide attempts and self harm. Reception Senior Officer A signed the Suicide Self Harm Warning Form at 12.20pm, indicating that he would be kept safe according to local protocols until he was assessed by medical staff.
22. Officer A, who with a colleague had been asked to cover the reception area over the lunchtime period, arrived in reception at about 12.30pm. The officer told the investigator that he was informed by an officer, whom he could not recall, that the man had arrived at the prison on a Suicide Self Harm Warning Form. He explained that because prisoners are not processed over the lunchtime period, and because the man was at a high risk of harming himself, he asked that he be placed in holding room 3. (A holding room is a room in which prisoners wait before being processed by the reception staff. Holding room 3, opposite the reception main desk, ensured that the officer could see him all the time.)
23. The officer confirmed with my investigator that the police memo to GSL arrived at Holme House with the Suicide Self Harm Warning Form and that he saw both documents. The officer said that he discussed the man’s situation with one of the reception nurses, Nurse A, Registered General Nurse (RGN) and team leader based in reception. He said:

“I spoke to the nurse and informed her of the paperwork that I had received. And it was decided that we would open an ACCT form on him [the man], which I did during the process of doing all the paperwork.”

The officer told my investigator that he could not recall seeing the doctor’s letter, adding that medical information received in reception would be passed straight to the nurses.

24. Whilst in reception prison staff recorded the man’s personal details on page one of his Core Record F2050 (The reception record completed for all new prisoners.) He told staff that his parents were his next of kin. A Cell Sharing Risk Assessment (CSRA) was also completed by Officer A. (A CSRA is used to assess the risk that a prisoner would present to others when sharing a cell.) The officer recorded that the man had previously harmed himself but did not have

any current thought of doing so, and that an ACCT had not yet been opened. He was considered suitable to share a cell. However, Nurse B, Registered Mental Nurse (RMN), the reviewing nurse did not indicate in section 3 of the form whether, following a self harm assessment, any concerns had been raised.

25. The officer also completed a number of other prison documents including an Induction/Resettlement Interview Sheet. (A document used as a check list that records further general information about a prisoner.) Nurse B completed the healthcare screening part of this form. She noted that there were no immediate concerns about the man and that he was fit to work. She also said that, although he was considered to be at risk of harming himself, he had asked that his family should not be notified of this fact. (This answers the family's question about why they were not told their son was at risk of harming himself. It was because he had specifically asked prison staff not to do so.) He signed a number of prison compacts confirming his understanding of prison rules and what was expected of him.
26. Officer A opened an Assessment, Care in Custody and Teamwork (ACCT) document on the man at 2.10pm. (ACCT procedures are used to assess, observe and support prisoners at risk of harming themselves. They highlight problems and possible trigger points of a prisoner at risk of harming himself and make a multidisciplinary plan to give support and help through a period of crisis.) He noted on the concern and keep safe part of the ACCT document that the man had made previous suicide attempts and had significant hand and wrist injuries, inflicted after the alleged murder of his partner. The officer recorded that he had been on constant close supervision whilst in police custody. The police memo to GSL was attached to the front of the ACCT document.
27. At 2.35pm the man was given a first night reception health screen by Nurse A, one of the reception nurses. (All prisoners are given a first night reception health screen when they come into prison. The aim of the screen is to identify any needs or health concerns that the prisoner might have. It includes identifying a prisoner's past medical history, including mental health.) She noted on EMIS, the patient electronic medical record, that a message from the police had indicated that he was at a very high risk of harming himself. She recorded that an ACCT document had been opened by discipline staff. However, he had stated that he had no thoughts of harming himself and explained that his injuries were as a consequence of self defence. She wrote that he was in receiving prescribed medications and was due to attend the orthopaedic clinic at hospital the following week.
28. She told my investigator that, although she had been given a message to say that he was at high risk of harming himself, she was not aware that he was on a "constant watch" when he arrived at the prison. She said the information she recorded on EMIS was provided to her by him alone. When asked if she saw the police memo to GSL, she said she had definitely not done so and had also not seen the letter from the police doctor.
29. The nurse, with Officer A, Nurse B and Nurse C RGN, agreed an immediate action plan which is part of the ACCT process. (Nurse A told the investigator

that she could not be sure when the immediate action plan was completed, saying that it was either before or after her earlier assessment of the man.) It was agreed by those present that he would be moved to the healthcare unit and placed in the camera cell. They also agreed that there should be a good quality conversation with him "... at least four times every 24 hrs", and he should be told about the Listener scheme. (Listeners are prisoners trained by the Samaritans to offer confidential support for prisoners in distress. They are available 24 hours every day and will meet prisoners to listen to their concerns.)

30. My investigator asked Nurse A about the frequency of observations, "4 entries after a quality interaction am pm ed-nocte [at night]". She explained that this was to ensure that he was spoken with at least this amount of times. When asked about the number of observations she said, "Well he was in safety cell conditions in a camera cell, so he would have been watched". When asked by my investigator, she said she could not recall discussing a referral for him to the mental health in reach team with either Nurse B or Nurse C, both registered general nurses.
31. Officer A said that, as a decision had been taken for the man to be placed in a camera cell in the healthcare unit; his understanding was that he would be on a constant watch. The officer said nurses took the lead in assessing prisoners at risk as they were better trained than discipline staff.
32. During the investigation my investigator established that Nurse D, Registered Mental Nurse for Handicap (RMNH) and Inpatient Healthcare Manager, signed the immediate action plan when the man arrived in healthcare. She said that she did not have any involvement with setting up the immediate action plan. However, as unit manager, she said she would check the form to see if it was sufficient, adding that it was based on her knowledge at the time.
33. The man was seen in reception at 3.15pm by Prison Doctor A. She recorded her contact in EMIS, noting,

"... very odd presentation, claims his hand/wrist injuries were caused in self defence and not deliberate self harm, this is not consistent with the police report ... denies any current suicidal ideas but I feel he maybe stating this in an attempt to get level of observations reduced in order for him to make further deliberate self harm attempts. Given the seriousness of his offence and previous history I feel he is extremely high risk of suicide and deliberate self harm and should be in healthcare in a safety cell with camera with very close observation."
34. At 3.30pm she recorded her contact with him in the on-going record of the ACCT document. She wrote that he was playing down his injuries, stating that he had no ideas of harming himself. However, she noted in the record that:

"I feel he is making this statement in order to get level of observations reduced in order for him to make further DSH [deliberate self harm] attempts. Needs very close observation in safety cell"

35. The man was transferred to the healthcare unit at 3.40pm and placed in a camera cell on the unit.
36. At 5.20pm Officer B conducted the man's ACCT assessment interview. He told the officer that his current problems related to accommodation and money worries, including his recent acts of self harm, lying on a railway track and cuts to wrists, which he said may have taken place during the alleged murder of his partner. He said his attempt to commit suicide was planned and that he had expected to die. However, he repeated that the injuries to his wrists were as a consequence of defending himself. When asked about current thoughts of harming himself, he said that "... life began at 40 and that he did not want to die".
37. A governor recorded in the man's wing history sheets that due to a potential security compromise he was to be transferred to HMP Durham and was not to return to Holme House.
38. The following morning, 28 April, he ate his breakfast. An unidentified member of staff noted in the on-going record section of the ACCT that, he had said he was okay and appeared in a good mood.
39. At 9.30am Senior Officer (SO) B, the segregation and healthcare unit discipline staff manager, chaired the man's first ACCT case review. The man attended the review, as did Nurse D. Officer B provided a verbal report. The SO noted in the ACCT document that the man was, "Currently located in healthcare due to injuries on his forearms (not deliberate self harm, wounds are from incident) also due to charge of murder." The man told the review panel that he was not thinking about harming himself and his main concern was having the dressings removed from his arms. The SO noted that he appeared quite calm and chatty throughout the interview and that the ACCT procedures were to remain open for ongoing observations. His next case review was scheduled for 1 May.
40. Although there is no indication whether or not the SO discussed a care plan with the man, he noted a number of issues and goals for him to achieve. They included, seeing the optician to assist with his reading problems, to integrate into prison life by going on association and stay in contact with his family. It was noted that he should be responsible for the last two of these actions and that healthcare staff would assist with his referral to the optician.
41. At 10.00am Officer C noted in the ACCT on-going record that the man was collected from the healthcare unit for onward transfer to Durham. The officer recorded that nurses had advised that he was considered to be at "high risk" of suicide, saying all the "classic things" of someone intent on doing so. He was taken to reception by the officer and was searched before being transferred to Durham. (His ACCT document and other prison records were sent with him to Durham prison.)
42. The man arrived at HMP Durham at midday. Officer D noted in the ACCT on-going record that he was quiet and subdued. In sections one and two of the CSRA, the officer recorded that the man had been charged with the murder of

his partner and was considered to be a high risk of suicide, having previously harmed himself. The officer also noted that it was his first time in prison and he was anxious about sharing a cell. Sections three and four of the CSRA were not completed by either healthcare staff or the locating discipline officer.

43. The officer also completed section one of a First Night, Induction and Initial Assessment form, although the remaining 11 sections of the form were not completed either by healthcare or discipline staff. The investigator asked Nurse E, RMN and healthcare inpatients manager, about the non completion of the induction process for prisoners taken straight to the healthcare unit. The nurse said that, although prisoners who arrive directly on the unit do not receive the same induction as those located on the wings, there are systems in place which informed prisoners of their routine, regimes, canteen and other prison matters.
44. At 12.30pm the man was admitted to the healthcare unit at Durham and located in cell M2-005, one of the unit's regular cells. (At the time of his admittance to healthcare at Durham both the gated cell and camera cell both used to continuously observe prisoners at a high risk of self harm, were occupied.) An entry in the ACCT on-going record noted that he, who was "quite chatty", had stated to staff that he did not know why he had been transferred to Durham and that although some of the injuries to his arms had been inflicted by his partner, others were self inflicted.
45. On his arrival in healthcare, he was seen by Nurse E. In an interview with my investigator, the nurse said that the man:

"... was a quiet chap. When he was first referred to us, we got a phone call from Holme House healthcare to say that he was en route ... We were painted a picture of a hugely depressed character but when he arrived he wasn't hugely depressed, he didn't present that way. He was very friendly, very polite, quite amenable to talk to, not particularly withdrawn. He had problems and he was anxious about his legal status because of his charge. But other than small issues that most prisoners have, i.e. needing phone credit, needing a smoker's pack etc, there was no particular concerns raised when he came to us; very pleasant very amenable."
46. The nurse wrote in EMIS that the man was in receiving antibiotics and painkillers for his injuries and was a high risk of harming himself. He reported no history of mental health problems but the nurse noted that he would be referred to the prison doctor and mental health team. The nurse told my investigator that he could not recall completing a manual or electronic referral to the mental health team, saying that the referral was almost certainly made verbally to the mental health team administrator. When asked by my investigator whether the referral was urgent or routine, the nurse said that because the man reported no history of mental illness the referral was most likely to have been routine.
47. Later that afternoon, sometime between 4.00pm and 5.00pm, Nurse F, RGN and acting charge nurse, completed a Healthcare Reception Assessment of Prisoner Transfer to Durham form. The nurse noted that the man neither reported nor acknowledged any current or previous mental health problems or special needs,

and that he was being observed four times a day whilst on an open ACCT. The nurse wrote that a further referral to a mental health professional would be required, as had been indicated by the entry in EMIS made by Nurse E. The nurse told my investigator that he believed that a referral to the MHIRT had already been made.

48. The man was observed further that evening. Health Care Assistant (HCA) A noted on EMIS that he was more settled, had taken a shower and been on association. The locum prison doctor who undertakes new reception health screens, wrote in EMIS that the man was suffering from minimal pain, that his mood was okay and he denied any thoughts of harming himself. Entries made by staff in the ACCT on-going record note that he remained settled, although low in mood.
49. At 5.50pm an entry in the ACCT on-going record notes that Nurse F, along with Officer E, another nurse and governor, undertook an informal review at which the induction procedures were explained. The nurse noted that no significant concerns were identified and described him as being amicable throughout, with positive body language.
50. Over the following days the man remained in the healthcare unit, was seen by the chaplain, received a visit, and continued to receive treatment for his injuries. HCA B noted on EMIS that he appeared happy and expressed no concerns. On 30 April, he mixed with other prisoners and told staff that he had had a good day. Nurse F told my investigator that he was not particularly withdrawn, attended association, exercise and interacted with the other prisoners. The nurse said that, during his contact with him, he did not express any thoughts of harming himself. HCA C said that he was quiet when he first came on to the healthcare unit and it took a week or so for him to settle in, adding that he was very polite.
51. On 1 May, the ACCT on-going record notes that the man had a visit from his solicitor, was quiet and polite on the wing, and continued to mix well with other prisoners. However, in a telephone call with his mother that afternoon, he complained of having no money or cigarettes, telling her that he wanted to “top himself” and would think of a way of doing so. (I have found no evidence from the Prison Service to suggest that they were aware of the contents of this or subsequent telephone calls.)
52. His first ACCT case review at Durham took place at 3.30pm and was chaired by Nurse G, RGN and team leader. Officer F and HCA D also attended together with the man. The case review reported that he had settled in healthcare, attended activities and was trying to come to terms with his crime. He told the staff that he did not feel at risk of harming himself. However, due to his recent attempts to harm himself, the review panel decided that his ACCT should remain open.
53. Notes in the ACCT on-going record and on EMIS indicate that the man voiced no problems and appeared in good spirits over the following days. His dressings were changed and he continued to mix with other prisoners on association.

54. However, on 2 May, he told staff he was fed up because it was Saturday night, although expressed no other concerns or issues. On 3 May, his dressings were again changed after he had removed the bandages and told staff that he wanted the stitches taken out. It was again noted in the on-going record that he expressed no worries or concerns.
55. On 4 May, he was recorded in the ACCT on-going record as being very interactive during association, speaking to both staff and prisoners. He was given his own clothes from reception and was reported as being pleased with this. Again he did not share any worries or concerns with staff. However, in a telephone conversation with his mother that afternoon, he told her that he felt depressed, not knowing what was happening. He told his mother that he again felt like killing himself and should have laid down under the train.
56. The man appeared at court, via video link, on the morning of 5 May. He was remanded at Durham until a further court appearance at Crown Court on 9 July. It was noted in the ACCT on-going record that he appeared to be settled before the video link, but was unsettled on his return, frustrated that his case would take another three months.
57. Later that morning, he spoke with his parents. He told them how he felt he would probably get a life sentence for what he had done, repeating that he wished he had killed himself by lying under the train. He became argumentative with his mother. He again talked of killing himself and said that he just wanted to die.
58. The man was a smoker and as a consequence of his dependence on tobacco, he asked for smoking patches. He was placed on the list to attend the smoking cessation clinic. In an entry that evening in his ACCT on-going record, it was noted that although he seemed settled he appeared a little anxious. He told staff that he wished the whole thing (meaning the offence against his partner) had not happened and that he was living with regret.
59. An administration officer for the mental health team made an appointment for the man to be seen by the community psychiatric nurse (CPN) from the MHIRT on 27 May.
60. On 6 May, he was reported in his medical record as having had no problems over night and his dressings were changed. HCA D said that he was feeling a little low about everything that happened and that he found the days were long.
61. The man's second ACCT review took place at 5.50pm. Nurse H, RGN, led the review as the case manager, with two other members of staff who had not been present at the previous meeting. He told the review panel that he was fed up. He had no thoughts of suicide or of harming himself at that moment, but could not say anything about the future. He was advised that staff were approachable and that he should speak with someone if he was thinking of harming himself. His level of observations remained the same and his next review was scheduled for 12 May. Entries in the ACCT on-going record that evening indicated that he

continued to interact with others and no further concerns were raised.

62. On 7 May, the man went to hospital for the removal of his stitches. HCA B noted on EMIS that he appeared in good spirits. On his return to Durham, he made a telephone call to his mother, who informed him that they had seen his solicitor who would be visiting the following Tuesday. His mother told him that it had been his partner's funeral the previous day and the news had been in the local press. He later made a telephone call to his aunt. He informed her that his case was in the local papers, that things were "doing his head in" and that he could not "handle it".
63. An entry in the ACCT on-going record on 8 May, notes that, on opening his post, he became very upset and angry and was desperate for tobacco. He told staff that he was "pissed off" and he was described as being very low in mood. However, in a later entry it is noted that he again expressed no worries or concerns to staff. An entry in EMIS by HCA E noted that he had attended all activities and taken his meal. Although he was concerned about a lack of tobacco, no other worries or concerns were voiced.
64. An entry in the ACCT record on 9 May indicates that the man collected his breakfast, cleaned his cell and went on association. He again told staff that he felt okay and expressed no concerns. Officer G wrote in the History Sheets that he:

"... appeared more settled in Durham healthcare, has started to take part in all healthcare have to offer, education, exercise, association. Mixes with his peer group and to date shown to be polite to all healthcare staff."

HCA C recorded on EMIS that he had had a settled day, taken his meals and, although he mixed with others, was very quiet and polite.

65. On 10 May, in the ACCT on-going record, HCA D noted that the man was agitated about not having any tobacco, felt really low and the reality of his charge had hit him. He told her that he could only think of cigarettes to keep him going. HCA B also made an entry in EMIS that he was not happy, asking for extra smoker's packs. He became agitated when he did not have any tobacco, but otherwise expressed no concerns. In the light of his predicament, she told the investigator that she organised for him to have an additional smoker's pack as he had missed ordering his through the prison canteen (prison shop). She said he kept ringing his bell and was agitated, as the reality of being in prison sank in.
66. The man spoke to his parents later that morning. He asked them to send in a fleece jacket and they told him that they would visit him the following week. Again he talked about "topping himself" and that he would find a way of doing so, repeating his wish that he had "gone under the train". He told his parents that things were not looking good. He said that he had had threats from people inside the prison, asking his mother whether she too had been threatened. Later that morning, Officer H noted that although he went out on exercise he declined to attend association. However, he did attend association after his lunch and

had a settled afternoon.

67. An ACCT entry dated 11 May, records that the man slept well, collected his breakfast and medication and attended education, but repeatedly asked for tobacco. After lunch HCA A wrote that he appeared very low in mood and, although he stated he was fine, was reluctant to engage in conversation. During the afternoon he went out on exercise and watched television with other prisoners. She spoke with him again in the late afternoon, reporting that he was very low he was sick of doing nothing as he was used to working, and needed to keep active.
68. An entry in the ACCT on-going record on 12 May noted that he had slept well over night. HCA C wrote that he took his breakfast and asked for a dressing to be applied to a wart, which he had picked and was bleeding. No other concerns were expressed. He ate his lunch. The last entry in his ACCT on-going record was made at 2.00pm. It said that he was agitated and asking for cigarettes, as he had missed ordering his canteen the previous week.
69. The man's third and final ACCT case review was held at 2.20pm. Nurse G led the review as the case manager and it was attended by HCA C, Nurse E and the man himself. The review panel noted his statement that he had no thoughts of harming himself and had settled in healthcare. The issue of his lack of cigarettes was highlighted along with his desire that staff should obtain some for him. The panel concluded that his ACCT document could be closed as his risk of self harming had reduced substantially. Nurse E made a note of the review panel's findings and conclusion on EMIS.
70. HCA C told the investigator that she could not recall the details of the ACCT review but that the man was polite, made good eye contact and talked "normally" to Nurse G. She recalled that tobacco was the main issue at the review with him saying that, as long as he had his tobacco, he would be fine.
71. Nurse E could not recall with certainty what was considered during the ACCT review or if any post ACCT closure plan was formulated. However, he said that the intention was for the man to remain in healthcare for ongoing observations and assessments. The nurse told the investigator that he

"... remembered him being very relaxed, quite chirpy, engaged well, good eye contact with the panel. I remember the issue of smoker's packs being brought up when we asked if he had any difficulties at the minute ... He said that he had no thoughts of suicide, that was all past, no intention of harming himself anymore. I remember thinking how well he's done, how far he's come and I was impressed with how bright he was, how well he was coping. As a mental health nurse there were no alarm bells ringing."

He said that he recalled him being asked about the ACCT being closed, and he was relaxed about it, feeling that he did not need the support.

72. The man telephoned his parents on the evening of 13 May. His mother explained that, due to his father being unwell, they would be unable to visit. He

told his mother how he was upset and asked whether his dog was alright. He again talked about money and clothes being sent in to him. HCA B noted on EMIS that his day had been quiet and he had not expressed any concerns. The following day, HCA A also noted that he had had a settled day and that no concerns had been raised.

73. At 3.09pm on 15 May, the man telephoned his aunt. He told her that he had a cold, was fed up and that prison was “doing his head in”. He asked his aunt if the police had been in contact and she reassured him that his solicitor would sort things out. An entry on EMIS by HCA E noted that he had a settled afternoon on healthcare, attending association and that there were no concerns at the time.
74. HCA C told my investigator that, on the morning of 16 May, the man collected his breakfast as usual. She said that there were no concerns, and he was polite to staff and prisoners. There was nothing in his behaviour which indicated to her that he intended to harm himself. After association, he collected his lunch around midday, before returning to his cell to eat. She said that he would have been locked up for the lunch period between 12.20pm and 1.30pm, being unlocked at around 2.00pm. However, due to a shortage of staff that afternoon, he and the other prisoners were not unlocked for the afternoon association period. Officer I told the investigator that the prisoners were informed they would not be unlocked after lunch that day. He said that when he collected his lunch he appeared fine, taking his lunch and a flask of hot water to enable him to make himself a cup of tea during the afternoon.
75. The investigator spoke with Prisoner A who exercised with and talked to the man. He said that he did not appear to grasp the severity of his offence, or the situation in which he found himself, and often talked about his dog. The prisoner said that he saw no sign that he was being bullied whilst in healthcare. He told the investigator that he did not go out that day but recalled hearing tearing sounds when dozing after lunch. He said he heard no more after falling asleep.
76. Prisoner B, a Listener, who talked with the man frequently during his time on the healthcare unit, said that on the day of his death he collected his lunch as usual and “seemed quite happy”.
77. At approximately 2.14pm Officer I opened the man’s cell door to give him a letter. He saw him suspended from the taps on the wash basin, appearing to be almost sitting on the floor. The officer immediately cut the ligature from around his neck whilst at the same time shouting for assistance. The ligature had been made from strips of bed sheets. HCA C, who was in the unit’s office nearby, responded to the officer’s shout for assistance. She went to the cell and, seeing what was happening, returned directly to the office to collect the emergency response bag.
78. Officer I told my investigator that he laid the man on the floor before radioing for emergency assistance. (The officer and nursing staff recorded in their incident statements that the man was discovered at approximately 2.10pm. Principal Officer (PO) A logged the time in his incident statement as 2.20pm. However, the incident log and control room daily log time the emergency call for assistance

as being at 2.14pm. The North East Ambulance Service Trust records that the man was found at 2.13pm. Having taken all the timings into account I believe it to be most likely that he was found at approximately 2.14pm.)

79. Nurse F told my investigator that he heard the emergency call for “Hotel 1 attend healthcare immediately”. He responded immediately, running up the stairs to the man’s cell. He arrived at the cell within 30 seconds of the alarm being raised. Nurse I, RGN and the designated emergency response nurse, along with Nurse J, RGN, who were both working in the reception area when the alarm was raised, also responded immediately.
80. Nurse F told the investigator that, when he reached the man’s cell, Officer I and HCA C were already there. At approximately 2.15pm he checked for signs of life whilst asking that a “code black” radio call be made in order to let all staff be completely clear about the severity of the situation and for an ambulance to be called. He checked the man’s vital signs, that are his pulse breathing and blood pressure, but there were none. He said that, although his pupils were fixed, there appeared to be no sign of rigor mortis. He started cardio pulmonary resuscitation (CPR) with the assistance of the HCA. He attached the Automated External Defibrillator (AED) which advised that no electrical shock should be applied. As a consequence he continued with breath and chest compressions on his own until the other two nurses arrived at approximately 2.17pm. The nurse told the investigator that in the absence of an ambu bag (a self-reinflating bag used during resuscitation), he was forced to give manual breaths through a face mask.

PO A, the Orderly Officer responsible for the day to day management of the prison, also responded immediately to the emergency call. On his arrival at approximately 2.16pm he saw the nurse giving CPR to the man. He said:

“I went to the office which was about two doors along from where the man was, which was the main healthcare office, and I rang the control room via 222 and checked that an ambulance had been called. This must have been about 30 seconds after I arrived in the healthcare centre, which was about two minutes after I would have had the request to attend the healthcare centre on the radio.”

81. My investigator established that the PO, by checking the ambulance had been called, was in fact the first person to have contacted the control room to request one. The control room daily log records that the ambulance was requested at approximately 2.19pm. Although the control room daily log records that an ambulance was called at 2.20pm, the North East Ambulance Service (NEAS) records show that the emergency call was actually made at 2.23pm. NEAS records indicate that the ambulance arrived at the prison at 2.26pm.
82. Nurses I and J were working in reception when they heard the emergency call to immediately go to healthcare. Whilst leaving reception they heard over their radios that the emergency was a code black. Nurse J told the investigator that, on their arrival a couple of minutes later at approximately 2.17pm, they found Nurse F unpacking the defibrillator. He nominated her to take control as she

was the AED trainer. Nurse J said the AED machine advised not to shock but to commence CPR. She took over compressions whilst the other two nurses concentrated on maintaining the man's airway. The nurses continued CPR until the paramedics arrived at approximately 2.35pm. The paramedics took control of the situation and continued CPR until he was taken to Accident and Emergency. NEAS records show that the ambulance left the prison at 3.03pm. Paramedics continued trying to revive him until his arrival at hospital at 3.08pm. However, he was pronounced dead at 3.15pm.

83. The members of staff who discovered the man were invited to attend a hot-debrief that afternoon. (A hot-debrief is a meeting held as soon as possible after a major incident.) A review of prisoners at risk of harming themselves was also completed. I understand that the officers involved in the incident were approached by the care and welfare team. Several officers said during interview that they were impressed by the level of care offered to members of staff.
84. The man's parents were told of his death by two family liaison officers early that evening. His parents commented to my family liaison officer of the kindness shown to them by prison staff following their son's death, describing the support they subsequently received as very good. They said that although they declined to visit the prison, they were pleased to have been invited to do so. They added that his personal belongings were returned promptly and in a sensitive way.
85. On 17 May, Prisoner C on the healthcare unit approached Officer I during morning association on learning that the man had taken his life the previous day. He told the officer that he knew it was him as he had told him that he was going to kill himself. When asked why he had not raised his concern with staff, the prisoner said that the man had told him not to tell anyone. That afternoon he told Nurse G that the man had been bullied due to the nature of his offence. He said that about four days before his death a prisoner on the wing had told him that he "... should string up because of what he had done".
86. As a consequence of the security information received, Officer J from Safer Custody made preliminary enquiries into the accusations of bullying made by Prisoner C, speaking with some of those prisoners involved. Without any evidence to substantiate the allegations, no further action was taken.
87. The investigator also spoke with Prisoner C. He told the investigator that the man was bullied by other prisoners on the unit because of his offence. However, he would not disclose who those prisoners were. He explained that most of the bullying took the form of name calling, giving the example of one prisoner saying to the man "you wanna top yourself given what you did". He claimed that healthcare staff knew he was being bullied but took no action. When asked who the man mixed with whilst on healthcare, the prisoner said that he was unable to provide the names of other prisoners with whom he was friendly, as this would identify those who had been bullying him. Nurse G told the investigator that she knew of no bullying whilst the man was alive and that the allegations of bullying were only reported after his death.

88. During his investigation of the man's death the investigator was unable to substantiate the allegations made by Prisoner C. However, he was satisfied that staff had not been aware of any bullying during the man's time in prison. When the allegations came to light, an appropriate investigation was conducted by the safer custody unit.

Post mortem

89. A post mortem was conducted on 18 May. The pathologist concluded that the cause of death had been pressure on the neck and the marks were consistent with partial suspension, such as would occur with hanging from a low level such as a tap. He reported no significant toxicological findings.

Thematic review of the last three self inflicted deaths at HMP Durham

90. Between 22 April and 18 May there were three self inflicted deaths at Durham. As a consequence of this cluster of deaths a thematic review was commissioned by the Acting North East Regional Manager for Custodial Services. The Safer Custody Advisor completed the review, reporting in July.

91. He reported that a common theme linking the deaths at Durham, including that of the man, was that all three men had been subject to the ACCT process, either leading to or at the time of their death. He reviewed the ACCT forms of all three prisoners. His findings with regard to the man's ACCT were:

- The first case review did not provide additional information to that supplied by the police and critically did not refer to comments made by the prison doctor at Holme House relating to the man's true intentions.
- The Care Map was extremely basic and contained three actions: see optician, integrate into prison life and stay in contact with family.
- On his transfer to Durham a case review was not completed within 24 hours.
- The case review held on 1 May, did not review or change the level of observations, and did not specify why continued camera monitoring was not considered.
- The following case reviews were of poor quality and did not examine progress against the caremap, custodial behaviour, referral to mental health services, current level of risk, frequency of observations or use of safer cells.
- Levels of observation at Durham remained the same as those set at Holme House.
- At the final case review no ongoing support for the man was provided.

He was also critical of the level and quality of management checks carried out

on the ACCT forms of all three men.

ISSUES

Transferring information between the police escorts and prison

92. On 26 April, whilst the man was in police custody, the Police Sergeant wrote a memorandum entitled 'GSL Further Information', with a marker attached, "Very Important". The Sergeant's memo to GSL provided a history of his time in custody since his arrest, flagging up significant self harm and suicide issues. The memorandum concluded that he should be placed on the highest category of suicide watch if remanded in prison and that document should accompany him at all times to inform the relevant authorities.
93. The following day, 27 April, the police doctor also wrote to healthcare staff and the man's carers, providing details of his medical history. The letter advised that he was at high risk of harming himself and, due to his "manipulative and narcissistic personality", would require a psychiatric follow up in prison.
94. The Holme House reception officer confirmed that the memorandum arrived with the Suicide Self Harm Warning Form, when the man arrived at Holme House, and that he saw both. However, he could not recall seeing the letter from the police doctor. Nurse A, the reception nurse, said that she did not see the memorandum, despite the officer telling the investigator that he brought the paperwork to her attention, but nevertheless the decision was made to open the ACCT procedures.
95. Nurse A conducted a first night reception screen. She noted on EMIS that a message from police had indicated that the man was at a high risk of self harm, was prescribed medication and due to attend hospital the following week. She said that she was not aware that he was on a constant watch and that the information she recorded was from him alone. She said she had definitely not seen the police memo to GSL and had never seen the letter from the police doctor. The investigator found both, the police doctor's letter, was in the man's medical record, and the police memorandum, was attached to the front of the ACCT document.
96. It is of the utmost importance that documents received into prison, and in particular those highlighting issues of a prisoner's risk of harming himself, should be processed appropriately and be seen by the relevant staff. Both the police memo to GSL and letter from the police doctor held such information and I am concerned that Nurse A says she saw neither during her assessment of the man. I note that she makes reference to information received by police in her entry in EMIS.

The Governor of Holme House should remind all reception and healthcare staff working in reception of the importance of treating all documents, and in particular those containing information about a prisoner's risk of harming himself, with care. The Governor should ensure that all staff are aware that any document containing information about a prisoner's risk is brought to the attention of relevant colleagues.

Assessment, Care in Custody and Team Work

ACCT – Immediate action plans

97. Although an immediate action plan had been completed by staff and contained actions for the man to be kept safe, the investigator found that the actions were rudimentary and did not appear to take into account his particular circumstances. The most notable omission was that no immediate referral was made to a member of the mental health in reach team. In order to find out whether this was an isolated case, the investigator also reviewed the immediate action plans of five other prisoners being monitored under ACCT procedures in healthcare. However, he was concerned to find that their immediate action plans were identical to that raised for the man. It appeared to him that staff had simply copied one immediate action plan to another. The ACCT procedures are designed to provide individualised support, but these action plans were carbon copies.
98. Prison Service Order 2700 (PSO 2700), Suicide Prevention and Self-Harm Management, Annex 8 G, states that, “Immediate Action Plans for prisoners considered to be at risk of suicide must at a minimum contain actions to prevent the individual carrying out suicide.” Indeed the instructions on the ACCT document itself, in the section titled immediate action plan, state that,
- “The purpose of this Immediate Action Plan is to consider and record the most appropriate environment and regime required, supporting the person at risk prior to the first Case Review.”
99. It is therefore to be expected that the immediate action plans of prisoners will differ, depending on their individual needs. However, it seems that a blanket approach to immediate action plans is taken by staff at Holme House with subsequent authorisation by the healthcare manager. Although offering some actions to protect and assist the man during his time of heightened risk, the action plan did not fully take into account his personal circumstances.

The Governor of Holme House should remind all staff of the importance of completing the immediate action plans for prisoners appropriately, taking into account individual prisoner’s needs and circumstances.

Frequency of observations and conversations

100. When the man arrived at Holme House, the ACCT procedures were opened by Officer A, the reception officer. It was recorded that whilst in police custody he had been watched continuously. An immediate action plan was raised by Nurse A and a number of other members of staff. It was decided that he should be located in a camera cell in healthcare and that four quality interactions a day should take place and be recorded in the ACCT document. Although there is no evidence to suggest that locating him in a camera cell, as opposed to continuous observation under constant supervision, led to any neglect or deterioration in his care, I have a number of concerns about staff understanding of this process.

101. The investigator established that some staff assumed that, because the man was in a camera cell and therefore observed on television monitors in the healthcare office, he would be observed continuously. During the investigation he visited the healthcare unit's office at Holme House monitors are located. He observed that the office was busy and, although the camera cells were monitored while officers and staff carried out other duties, there was no one monitoring them continuously. He was told that no specific member of staff was dedicated this task, but that the cells were monitored by whoever was in the office at the time.
102. SO B, said that, because the man was in a camera cell and there was a television monitor in the healthcare office, a member of staff would be watching him all of the time. However, when further questioned about the use of the camera cell, he agreed that staff might use the camera cell as an alternative to a prisoner being observed continuously. He added that prisoners in camera cells did not have specific numbers of ACCT observations made on them.
103. Nurse D told my investigator that the four observations a day entered on the front of the man's ACCT document related to what was actually to be written in the on-going record of the ACCT document. She said that he would have been watched all the time on the television monitor, there being somebody in the office all of the time. She also said that staff would not put the actual number of observations on the ACCT document unless they were really concerned about a prisoner.
104. Whilst checking the immediate action plans of ACCT documents open in healthcare on the day of his visit, my investigator also checked the number of observations prescribed for other prisoners on open ACCTs. He found that the observations on the other ACCT documents were identical to those recorded for the man, namely four quality entries a day.
105. Consequently, it would appear that staff at Holme House are, as with their entries in the immediate action plans of ACCT documents, taking a blanket approach to the number of observations deemed necessary for prisoners in camera cells. The number of observations made on a prisoner should be based on the individual's needs and risk of harming himself. A blanket approach is not appropriate.
106. Holme House's own policy on Suicide and Self Harm Prevention is clear in that it states that both levels of observations and conversations required for an individual prisoner must be recorded on the front cover of the ACCT document in a clear and specific way.

The Governor of Holme House should remind staff that when deciding on the number of observations that a prisoner requires, on an open ACCT document, they must ensure that they are relevant and pertinent to the prisoner's individual needs and risk.

107. The investigator was not reassured that healthcare staff at Holme House were confident about the difference between a prisoner being placed in a camera cell

and constant supervision. I observe that Holme House's Suicide and Self Harm Prevention Strategy is clear in distinguishing between the two, and the appropriate action to be taken with regard to each.

The Governor of Holme House should ensure that all healthcare staff are aware of the differences between a prisoner being placed on constant supervision and a prisoner being located in a camera cell.

ACCT reviews

108. The man's first ACCT review at Holme House was chaired by SO B. Nurse D also attended, as did the man. However, Officer B, the ACCT assessor who would have known most about him at that point in time, did not attend and only provided a verbal report. The officer told the investigator that it was not common at Holme House for ACCT assessors to attend the first ACCT review, adding that he would be happy to participate in a review if asked. The SO also told the investigator that ACCT assessors were not usually present at a prisoner's first case review. He could not specifically recall discussing the man's assessment with the officer that morning.
109. PSO2700, Suicide Prevention and Self-Harm Management, Annex 8G, paragraph 10, says that the assessor must contribute to the first case review by attending if at all possible, otherwise in writing or by telephone. I appreciate that not all assessors will be able to attend all first case reviews. However, given that ACCT assessors do not routinely appear to attend first case reviews at Holme House, I make the following recommendation.

The Governor of Holme House should remind staff that ACCT assessors, where possible, should attend first case reviews.

ACCT reviews on transfer to another establishment

110. Although an informal ACCT review was undertaken when the man was transferred to Durham on 28 April, and noted in the ACCT on-going record, he was not formally reviewed until 1 May. As a consequence, and contrary to PSO 2700, no formal review was completed. A review would have included a review of his care map and the number of observations that he was placed on. Nurse G, the case manager appointed at Durham, told my investigator that she could not recall why a case review was not completed when he transferred from Holme House.
111. PSO2700, Suicide Prevention and Self-Harm Management, section 4.6.1 clearly states that it is a mandatory requirement that an ACCT review must take place within 24 hours of a prisoner's arrival at a new prison. It states that upon transfer staff should also check the frequency of conversations and observations and review the care map.

The Governor of Durham should remind all staff that, when a prisoner is transferred in from another prison on an open ACCT, a case review must

be completed within 24 hours of his arrival.

Use of background information in ACCT reviews

112. A formal ACCT review took place on 1 May. It was led by the case manager, Nurse G. The review recorded that the man was settling in to prison. He told staff that he did not feel at risk of harming himself. Although this information was recorded, there is no indication that consideration was given to reviewing the number of conversations and observations with him or his care plan. Both remained unchanged from the levels previously set by staff at Holme House. In addition the letter from the police doctor and the police memo to GSL appear not to have been considered even though he had been in custody for a relatively short time.
113. When questioned, the nurse told my investigator that consideration of the appropriate number of observations would have happened during the review. She said that she did not see the police warning form attached to the front of the ACCT document and could not recall reading the previous entries made by staff at Holme House, including the entry by Prison Doctor A. She said that, had she seen either of the documents, or the entry by the doctor, she might have changed the level of ACCT observations.
114. As I have already indicated in this report, it is of the utmost importance that documents received into prison are seen by the relevant staff and referred to appropriately in ACCT reviews. As at Holme House, staff at Durham appear not to have considered the important information that was present in the man's medical record and attached to his ACCT document.

The Governor of Durham should remind all staff of the need to read all information accompanying prisoners who transfer on an open ACCT and indicate in ACCT case reviews when such information has been considered. Additionally the Governor must remind staff to consider the number of observations and care plan at all ACCT reviews and note their decisions.

Continuity of staff at ACCT reviews

115. There was little continuity amongst the staff attending ACCT reviews. The man's second case review at Durham took place on 6 May at 5.50pm. Nurse H led the review as the case manager. Two other members of staff who were not present during the first case review also attended. The nurse told the investigator that he completed the review as he was in the healthcare unit that evening. At his review on 12 May, Nurse G resumed her role as case manager and was assisted by HCA C and Nurse E, neither of whom were present at the previous reviews. The HCA told the investigator that she remembered attending the review. She said that generally whoever was in the office at the time would attend and the same member of staff would not necessarily be invited to all of the reviews. It is clear that different members of staff were present at each of his reviews and that this was not unusual.

116. PSO2700 Suicide Prevention and Self-Harm Management (Annex 8G) states that, when ever possible, the case manager appointed to lead the case reviews should arrange subsequent reviews at a time when they can be present. This is to provide continuity of care for the prisoner. Haphazard and occasional attendance is disruptive for the prisoner and is not in the spirit of the ACCT procedures. It is particularly disappointing that the healthcare staff did not ensure more consistent attendance.
117. I believe that attendance by different members of staff at the man's case reviews may well have undermined the level of understanding of his needs. The case manager allocated to a prisoner at risk should remain the same as far as is possible, as should the other staff, for the duration of the ACCT document in order that the prisoner receives consistent support from familiar staff. Although the lack of continuity may not have had any bearing upon his eventual actions, I make the following recommendation.

The Governor of Durham should ensure that the case managers, and reviewing staff, where possible, remain the same during the duration of a prisoner's ACCT monitoring so that he receives consistent support from familiar staff.

ACCT Training

118. During the investigation a number of the healthcare assistants at Durham told the investigator that they had not been trained in the ACCT process, but nonetheless had contributed to it, either by attending reviews or writing directly in the on-going record.
119. PSO2700, Suicide Prevention and Self-Harm Management, section 1.11 states that,
- “... all staff in contact with prisoners need to be aware of and trained to ACCT foundation level. Therefore it is important that Healthcare Managers – through their Partnership Board – make every effort to ensure the local training strategy reflects this in respect of all healthcare staff (agency wherever possible and permanent employees, whether existing or new) and mental health in-reach teams.”
120. I make no criticism of the HCAs who had a good understanding of ACCT process. However, I am disappointed to learn that they have not been provided with formal training.

The Governor and Healthcare Manager of Durham must ensure that all healthcare staff receive at least foundation level training in ACCT.

Referral to the Mental Health In-Reach Team

121. Despite the man's recent history of self harm and attempts at suicide Nurse A at Holme House did not refer him to the MHIRT, either during the initial assessment or as an action in the ACCT immediate action plan. Nurse D said that a referral

to the MHIRT would be made at reception if it was required.

122. On his arrival at Durham the man was assessed again by Nurse E. He noted in the medical record that, although he was considered to be at a high risk of harming himself, he reported no history of mental health problems. The nurse told the investigator that, although he could not recall making a written referral to the MHIRT, he believed that he did make a verbal referral to the MHIRT's administrator.
123. Upon further investigation the investigator discovered that the man's referral to the MHIRT was picked up by the team's administrator when completing a second check of prisoner medical records, when it was noted that he was to be referred. Because no additional information was available to the administrator, his appointment was processed as routine.
124. Despite his high risk of harming himself, including recent attempts to harm himself, the nature of his offence and recent admittance to hospital under the Mental Health Act, prison staff at Durham did not refer him urgently to the MHIRT. Although Nurse E made a verbal referral, noting it in his medical records, no urgent written referral was made.
125. I cannot stress sufficiently how important the speedy identification of prisoners with mental health problems is in order that the correct care can be provided and a level of priority be assigned. I am concerned that, despite the man's recent history, an urgent referral to the MHIRT was not made.

The Healthcare Managers of both Holme House and Durham should remind staff of the need to make urgent referrals to the MHIRT for prisoners who have either recent or established histories of attempted suicide or self harm.

The Healthcare Manager of Durham should remind all healthcare staff of the need to make written referrals to the MHIRT and ensure that a level of priority is set when referring prisoners.

126. In her clinical review the clinical reviewer comments that, despite external correspondence from mental health services, it seems that no attempt was made by healthcare staff at Durham to obtain further information from either hospitals. She says:

“There seems to have been an over reliance on what the man self-reported to the healthcare staff about any previous mental health issues, and none, or very little, objective psychiatric assessment made by healthcare staff. This was despite correspondence from the police and Holme House that described him as ‘possibly manipulative and may try to get level of observations reduced in order for him to make further deliberate self-harm attempts’”.

She recommends that NHS County Durham should ensure that:

Processes and systems for managing and responding to external communications should be reviewed to ensure healthcare staff act promptly upon key patient information when it is received from external agencies.

A formalised and recognised mental health risk assessment tool should be implemented and adopted by healthcare staff without delay; any associate workforce development and business change issues should be actively dealt with and managed.

Record Keeping

127. The clinical reviewer reports that the man's electronic health records do not consistently include the name and designation of the health professional making entries. She also says that, to compound this oversight some of the handwritten documents are illegible. She comments that this does not comply with the professional code of practice of the Nursing and Midwifery Council (NMC), Record Keeping Guidance for Nurses and Midwives. She recommends that NHS County Durham should ensure that:

A record keeping audit should be carried out to check healthcare staff's compliance with NMC professional standards.

Healthcare care plans and nursing assessments

128. The clinical reviewer observes that the man's ACCT document seems to have been used by staff in healthcare as a substitute for a nursing care plan. She writes:

"This, of course, is appropriate where nursing care is not indicated. However, as the man was located in a healthcare setting and presumably receiving some element of nursing care then the clinical reviewer would have expected some evidence of using assessment and care planning. Consequently, there is no evidence of any form of mental health risk assessment or mental healthcare planning. The clinical reviewer considers this to be both surprising and of concern when one takes into account his earlier serious apparent suicide bid and admission to psychiatric care (albeit as an informal patient)."

She recommends that NHS County Durham complete:

A review of how the clinical nursing process operates in the healthcare centre's inpatients, i.e. nursing assessment, planning, implementation and evaluation processes, and the development of a case management approach should be considered.

Delay in calling an ambulance

129. The investigator established that from the time the man was found at 2.14pm it was not until nine minutes later, at 2.23pm, that an ambulance was called. Officer I said he did not ask for an ambulance to be called and he did not know

who subsequently requested one. Nurse F said that, although he asked for an ambulance to be called shortly after his arrival, he did not call it himself. Additionally Nurse J said neither she nor Nurse I made the call, adding that it was PO A who confirmed that an ambulance was on its way.

130. I appreciate that timings may not be completely accurate but it would appear that the PO was the first to call an ambulance some nine minutes after the original emergency call was made. It is essential that ambulances are called immediately to emergency situations such as this. Any delay can have a significant impact on a person's chances of survival. If it is not required the ambulance can be cancelled but it is better to err on the side of caution.

131. A Letter to Governors from the Director of Prison Health in March 2004 advised that it was their responsibility to ensure a protocol existed to facilitate immediate access for the paramedic services. The letter advises that:

“It is also essential that internal procedures should not waste undue time in summoning emergency assistance. It should not, for example, be a requirement in every case for a member of the Health Care Team to attend the scene before Emergency Services are called. However, a subsequent 999 call to the Ambulance Service should be made to cancel the response if, after the original 999 call has been made, a member of the Health Care Team arrives with the patient and deems that an emergency ambulance response is not required.”

132. I note that HMP Durham have a clear policy for calling an ambulance. Their protocol for the attendance of an Emergency Ambulance provides clear instructions to staff as to when an emergency vehicle should be summoned. The protocol was not followed and so I make the following recommendation.

The Governor of Durham should remind all staff of the importance of calling an ambulance promptly, referring them to the local protocol relating to the attendance of emergency vehicles.

133. The investigator also learned that, once the PO had asked for an ambulance to attend, there was some confusion in the control room as to which telephone should be used. This led to a delay of approximately one minute before the call was eventually made to the emergency services.

The Governor of Durham should satisfy himself that all staff working in the control room know which telephone should be used to summon an emergency vehicle.

Missing equipment

134. Nurse F said that when he tried to resuscitate the man he had to administer manual breaths through a face mask, because the ambu bag was missing from the emergency response kit. His view was that, although the lack of the ambu bag did not hinder his attempt to resuscitate him, using one might have meant that his efforts were more effective.

The Healthcare Manager at Durham must ensure that the contents of the emergency response bags are checked regularly and that used equipment is replaced immediately.

CONCLUSION

135. Upon the man's transfer from police custody into prison, staff immediately identified that he was at risk of harming himself. However, the letter from the police doctor and police memo to GSL, written by the Sergeant, went unnoticed by a number of staff at both Holme House and Durham. As I have indicated in my report, I find this to be a cause for concern. I am also concerned that, despite his recent history of attempting to harm himself and the nature of his offence, he was not referred for mental health support. Consequently there was no assessment of his mental health during the two weeks that he spent in the prison. Additionally the ACCT document completed by staff at both Holme House and Durham was, as I explained, lacking in a number of ways.
136. The man was at great risk of killing himself during his first few weeks in prison. In the days leading to his arrest he had been admitted to hospital under the Mental Health Act, having been found contemplating taking his life on a local railway line. He had allegedly killed his partner on 21 April and at the same time made multiple cuts to his hands and forearms.
137. Although healthcare staff were satisfied that he was settling into prison life and was only troubled by the shortage of tobacco, other prisoners and his family thought otherwise. Staff at Durham, in the days leading up to his death, were not aware that he had told his parents in telephone calls on 1, 4 and 10 May that he was thinking of killing himself. It is probable, that having determined to take his life, no intervention would have stopped him from doing so. However, there remains the possibility that closer and continued observation of him through the ACCT process and more appropriate mental health assessment might have altered the outcome.

RECOMMENDATIONS

HMP HOLME HOUSE

1. The Governor of Holme House should remind all reception and healthcare staff working in reception of the importance of treating all documents, and in particular those containing information about a prisoner's risk of harming himself, with care. The Governor should ensure that all staff are aware that any document containing information about a prisoner's risk is brought to the attention of relevant colleagues.

Accepted

An audit in March 2010 involved speaking to those staff working in Reception and they explained the process of dealing with a self harm warning form – the self harm warning form is signed by the Reception Officer who then places the copy in the core record. The core record is placed at the top of the in-tray for Healthcare staff and they sign the form on receipt. The Healthcare staff working in Reception stated that System One asks if there is any information regarding self harm, the warning form information is used and recorded. A copy is kept in the IMR, F2050 and in the ACCT if one is to be opened. All Reception and Healthcare staff working in Reception will be reminded accordingly.

2. The Governor of Holme House should remind all staff of the importance of completing the immediate action plans for prisoners appropriately, taking into account individual prisoner's needs and circumstances.

Accepted

A Notice to Staff to be issued. Information/guidance to be issued in the Monthly Briefing. All managers and Safer Custody staff to be reminded to be aware of the need to ensure to include the checking of the immediate action plan during their daily management checks of ACCT documents.

3. The Governor of Holme House should remind staff that when deciding on the number of observations that a prisoner requires, on an open ACCT document, they must ensure that they are relevant and pertinent to the prisoner's individual needs and risk.

Accepted

A Notice to Staff to be issued. Information/guidance to be included in the Monthly Briefing. To be included in ACCT Case Manager training.

4. The Governor of Holme House should ensure that all healthcare staff are aware of the differences between a prisoner being placed on constant supervision and a prisoner being located in a camera cell.

Accepted

This is in place. The use of CCTV in the Healthcare Centre was reviewed and a new policy was written and issued. This policy will be included in the local Suicide and Self-Harm Prevention Strategy which is currently being reviewed.

A number of constant watches have taken place since October 2009 – one was for a prolonged period. A constant watch would normally take place in the gated cell in the Healthcare Centre with a member of staff detailed the constant watch on a one-to-one basis either at the door or wherever the prisoner goes to. If a prisoner is in a camera cell for observation, then a member of staff, either discipline or clinical, will constantly observe the monitor in the Healthcare Main Office.

5. The Governor of Holme House should remind staff that ACCT assessors, where possible, should attend first case reviews.

Accepted

A Notice to Staff to be issued. Residential Managers to be made aware. ACCT Assessors to be made aware.

HMP HOLME HOUSE and HMP DURHAM

6. The Healthcare Managers of both Holme House and Durham should remind staff of the need to make urgent referrals to the MHIRT for prisoners who have either recent or established histories of attempted suicide or self harm.

Accepted

All clinical staff working within HMP Holme House will be informed about this recommendation via e-mail.

All clinical staff working within HMP Durham will be informed about this recommendation- via E-mail.

HMP DURHAM

7. The Healthcare Manager of Durham should remind all healthcare staff of the need to make written referrals to the MHIRT and ensure that a level of priority is set when referring prisoners.

Accepted

All clinical staff working within HMP Durham will be informed about this recommendation- via E-mail. The timescale of assessment will be identified by the initiating nurse/or other. Mental Health Referrals can be received either in written or electronic template format. All mental health referrals are

triaged by the mental health team the next working day, whereby they are logged and allocated to the most suitable practitioner.

8. The Governor of Durham should remind all staff that, when a prisoner is transferred in from another prison on an open ACCT, a case review must be completed within 24 hours of his arrival.

Accepted

A Notice to Staff to be issued. Information to be included in the Monthly Briefing. Note to staff to be issued.

9. The Governor of Durham should remind all staff of the need to read all information accompanying prisoners who transfer on an open ACCT and indicate in ACCT case reviews when such information has been considered. Additionally the Governor must remind staff to consider the number of observations and care plan at all ACCT reviews and note their decisions.

Accepted

A Notice to Staff to be issued. Information to be included in the Monthly Briefing. All Senior Officers, including Induction and Reception, to be e-mailed this information. Head of Offender Health to be e-mailed this information. Sarah Wilson, DPSM for HB 7, to be e-mailed this information. Note to staff to be issued. First Night Centre and Reception Senior Officers E mailed.

10. The Governor of Durham should ensure that the case managers, and reviewing staff, where possible, remain the same during the duration of a prisoner's ACCT monitoring so that he receives consistent support from familiar staff.

Accepted in Principle

HMP Holme House now operates a central detail system. It is therefore very difficult to ensure consistency of a certain Senior Officer on a particular house block.

HMP Durham- Due to the system of SO's not always covering the same wing difficult to maintain continuity to enable the case manger to attend case reviews.

Induction / First Night Centre SO's will be reminded to make themselves aware of all relevant information appertaining to prisoners who may be at-risk of self harm due to their current circumstances.

11. The Governor and Healthcare Manager of Durham must ensure that all healthcare staff receive at least foundation level training in ACCT.

Accepted

Holme House- ACCT Foundation Training began again in June 2010. Due to a shortage of ACCT trainers, two staff have been identified to embark on a Trainer for Trainers Course to enable them to deliver ACCT Training in Holme House.

Healthcare staff are made aware of the available ACCT Foundation Training and all staff in Healthcare who require this training is currently been compiled. Healthcare staff will be prioritised to receive this training.

Durham- Following recent audit of standard 60 identified that all HCC staff will receive A.C.C,T by November 10

12. The Governor of Durham should remind all staff of the importance of calling an ambulance promptly, referring them to the local protocol relating to the attendance of emergency vehicles.

Accepted

Holme House- This will be included in the 'Protocol for Calling Emergency Vehicles' located in the Communications Room.

Durham- Protocol for calling Emergency ambulance inserted into Control room incident file.

13. The Governor of Durham should satisfy himself that all staff working in the control room know which telephone should be used to summon an emergency vehicle.

Accepted

Holme House- In place. All staff working in the Communications Room know they must dial 999 to summon an emergency vehicle. It is also included in the protocol above (12)

Durham- Dedicated line direct to Emergency Services. Officer I/C to inform all staff working in the control of the dedicated line.

14. The Healthcare Manager at Durham must ensure that the contents of the emergency response bags are checked regularly and that used equipment is replaced immediately.

Accepted

Holme House- In place. Weekly emergency bag checklists take place. All Healthcare staff will be reminded to restock bags after use.

Durham- All emergency bags are checked routinely on a weekly basis and restocked when required. All staff will be reminded to restock bags after use. Weekly emergency bag checklists are completed by nursing staff and returned to the Primary Care Co-ordinator for monitoring/records.

NHS COUNTY DURHAM PRIMARY CARE TRUST

15. Processes and systems for managing and responding to external communications should be reviewed to ensure healthcare staff act promptly upon key patient information when it is received from external agencies.

Accepted

Durham – Healthcare Admin Manager to implement daily update of prisoners currently residing in outside hospitals, which HCC I/C will utilise to make daily contact for info. Correspondence received from outside hospitals/appointments follow an established audit trail and are signed by Admin Manager, HCC I/C & GP, with any points arising being actioned by each party.

Prison Staff escorting prisoners to outside hospital appointments to be regularly reminded of the importance of passing on information/correspondence/medication etc to a member of Healthcare Staff in person, upon return from escort.

16. A formalised and recognised mental health risk assessment tool should be implemented and adopted by healthcare staff without delay; any associate workforce development and business change issues should be actively dealt with and managed.

Partially Accepted

A formalised and recognised mental health risk assessment tool appropriate to the prison environment is yet to be developed. Mental health team/clinical governance team will look into adapting existing risk assessment tools for use in prison environment.

17. A record keeping audit should be carried out to check healthcare staff's compliance with NMC professional standards.

Accepted

Monthly record keeping audit of 10 random prisoners' medical records to be carried out by a designated member or Healthcare staff, detailed via the Primary Care List within the Staff Detail – Audit tool to be developed in line with NMC guidance.

18. A review of how the clinical nursing process operates in the healthcare centre's inpatients, i.e. nursing assessment, planning, implementation and evaluation processes, and the development of a case management approach should be considered.

Accepted

A review of the nursing process within the Healthcare Inpatients area will be carried out. Case Management approach is effectively already in place, in that only one member of staff is permanently detailed HCC Inpatients, therefore co-ordinates care for all inpatients.