

**Investigation into the circumstances surrounding the
death of a man at HMP Durham
in July 2006**

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

November 2007

This is the report of an investigation into the circumstances of the apparently self-inflicted death of a man at HMP Durham on 5 July 2006. I pass on my sincere sympathies to his family.

Arriving in England as a refugee in 2000, the man was serving an indeterminate sentence for his first offence, wounding with intent to cause grievous bodily harm. At the time of his death, he was working in the coveted position of cleaner in the prison's chapel. He was highly thought of by prisoners and staff alike.

My investigator received excellent support from the Safety and Decency team at Durham prison. I would also like to thank the Governor of Durham, for the time and resources that he and his staff gave throughout the investigation process.

I am grateful too to the clinical reviewer for his prompt review of the man's clinical care throughout his time in custody.

I agree with the the clinical reviewer that the staff response to this emergency was swift and well-managed. Nevertheless, I have identified room for improvement and make three recommendations to HMP Durham. I also make a recommendation to the National Offender Management Service regarding the provision of places for those serving indeterminate sentences. I also commend two members of Durham staff: the Lifer Manager who made a presentation to prisoners about how indeterminate sentences work, and the Safer Custody Manager for the sensitively conducted family liaison which was demonstrated following the man's death.

This report raises important questions about the sentence of Imprisonment for Public Protection (IPP) and the extent to which the Prison Service can currently provide for those serving such sentences.

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SUMMARY

The man fled persecution in his home country to start a new life with his wife in England in 2000. Things were not easy for them, and in July 2005 the man and his wife had a violent confrontation in her home. Following this, the man was convicted of wounding with intent to cause grievous bodily harm and assault. In January 2006, he received an indeterminate sentence for public protection (IPP) with a three year tariff.

After being treated for a self-inflicted wound to the neck, the man was remanded to HMP Durham on 1 August 2005. Over the year that he spent at Durham, he took all of the available life skills classes to address his offending behaviour, including domestic violence and anger management classes. He was selected to work as the chapel cleaner because of his impeccable attitude. The job of chapel cleaner meant that he was transferred to the enhanced prisoner unit in Durham.

The man was subject to formal suicide prevention measures on only one occasion. This was for three weeks in October 2005 after staff noticed that he had been badly affected by a court appearance. He was made subject to 15 minute observations at that time. The man told staff that his main concern was the welfare of his two young twin boys. He was referred for a mental health review and his medication was changed. Probation staff at the prison made efforts to contact Social Services about the welfare of his children. The man told staff that he felt much better after getting information about his children, as well as the change in his medication. As a result, his self-harm monitoring and support form was closed.

Following his sentencing, records show that the man was extremely confused about how the indeterminate sentence worked. Efforts were made by staff to explain that he had received the equivalent of a life sentence with an earliest release date in three years time.

Prisoners who receive life sentences, including IPP sentences, must generally complete certain courses before they can be successful in an application for release on licence. However, the increase in the number of prisoners receiving indeterminate sentences, coupled with general prison population pressures, mean that there are serious delays in prisoners' progression through the lifer system. The man was told that it was unlikely that short tariff prisoners, like him, would be released at their earliest possible release date. He knew that he had to be transferred to Manchester before he could begin his sentence plan. There is no doubt that the uncertainty of his sentence affected the man's mental state and I have made a recommendation relating to this.

The man was attending a Social Awareness course in the week that he died. He attended the course as usual on the morning of 5 July. Prisoners who also attended said that he seemed fine that morning - in fact "fresher" than usual. At lunchtime, the man collected his lunch and ordered food for dinner the following day. He returned to his cell with his meal and was locked in for the lunchtime period. He was discovered hanging in his cell by a fellow prisoner delivering laundry after lunch.

THE INVESTIGATION PROCESS

1. My investigator visited Durham on 11 July to collect copies of the man's prison records. A member of the Safety and Decency team was appointed to be the liaison officer and showed the investigator around the prison. She met with the Governor, the Head of Healthcare, and with representatives from the local branch of the Prison Officers' Association and the Independent Monitoring Board.
2. Over several follow-up visits, the lead investigator, with the assistance of a fellow investigator, conducted interviews with key members of staff at the prison and with a number of the man's fellow prisoners.
3. A family liaison officer from my office was accompanied by the assistant investigator on a visit to the man's cousin's home. There they met with the man's mother and wife to explain the investigation process and to give them the opportunity to express any concerns to be addressed during the course of my investigation. The family told my colleagues that, during their meeting with the Governor, they had been told that the man had adjusted well to life in the prison. As a consequence, they found it difficult to believe that he would consider suicide. They were also concerned that the man was not subject to suicide prevention procedures at the time of his death. The man's mother was troubled that she understood that he was not allowed to have photographs of his children that she had sent to him in his cell. In fact, my investigation found that he had many photographs of his children in his cell. I trust that I have dealt with these concerns as far as possible in the report.
4. A doctor was appointed by Durham and Chester-le-Street Primary Care Trust (PCT) to conduct a clinical review into the man's medical care while he was in prison, and the emergency response on 5 July. I would like to thank the clinical reviewer for his comprehensive and prompt review. He made no recommendations.

HMP DURHAM

5. Durham is a male local prison that holds prisoners who are due to make a court appearance and some who have been sentenced. It accommodates up to 919 men. Some pass through Durham quickly, whereas others like the man spend a significant amount of time there. Durham runs an 'integrated' regime, which means that everyone lives alongside one another, regardless of the nature of their offence or vulnerability.
6. Despite holding a considerable number of prisoners sentenced to an indeterminate sentence for public protection, there is no lifer unit at Durham. It looks after prisoners who are awaiting transfer to a lifer unit but cannot offer much by way of relevant courses or programmes.
7. Previously, Durham had a high security female unit. The female unit has since been transformed into an enhanced wing for prisoners who have earned additional privileges through respectful behaviour. This was the unit where the man was located at the time of his death and where he died.
8. Her Majesty's Chief Inspector of Prisons carried out an inspection of Durham in September 2006 (the report of that inspection was not available when this investigation was being undertaken). The latest available inspection report for Durham's male prison is that following an unannounced inspection that took place in August 2003. The Chief Inspector commended Durham for its "reception, suicide and self-harm and anti-bullying work". She recognised that, "relationships between staff and prisoners were consistently good". Overall, she felt that Durham was "a fundamentally safe and decent environment". However, she suggested that too little was being done in terms of "purposeful activity" so that prisoners were unable to acquire new skills to prevent a swift return to custody.
9. At the time of writing this report, the man's death was the eighth apparently self-inflicted death at Durham since April 2004.

KEY EVENTS

10. The man was still on prescribed medication when he arrived at Durham prison on 1 August 2005. A first reception health screen was carried out on the day of his arrival. (This assesses if an individual has any urgent medical issues that need immediate attention, or ongoing issues that may need to be referred to other specialists.) Following the screen, he was referred to the prison doctor and for a mental health assessment.
11. The health screen also examines whether a prisoner is at risk of suicide or self harm. A health care officer undertook the man's health screen. The health care officer could see that the man had cuts to his neck and his wrists. He was aware of the nature of his offence. He also knew that, given both of these risk factors, Global Solutions Limited (the company that escorted the man to and from court) had placed a deliberate self-harm warning on his records. The health care officer questioned the man about this. He assured the health care officer that he no longer had thoughts of self-harm because he understood what effect this would have on his children. In fact, the man was ashamed that he had harmed himself. The health care officer recorded that the man had cut himself immediately after his offence, but decided that he did not need to be put on self-harm monitoring procedures and felt his suicidal thoughts had passed.
12. The following day, a letter was sent to the prison from the hospital where the man had received treatment for his neck and arm injuries. The letter informed the prison that he had an appointment with the Plastic Surgery department two weeks later. It also recommended that the man be referred for further investigation following an epileptic fit that he suffered while being treated at the hospital. The man had not suffered from epilepsy before this fit.
13. A further health review took place on 4 August. The man's mood was described as "satisfactory" and he was recorded as having no suicidal thoughts. This was echoed by a registered mental health nurse's assessment of his mental state the next day. He was thought to be coping, with no thoughts of self-harm.
14. A full mental health assessment was carried out on 10 August. The man was found to be suffering from 'reactive' depression, caused by the circumstances he found himself in. According to the report, he was not considered to be a "current self harm risk".
15. Over the following weeks, the man was treated for chest pains apparently caused by anxiety. He was moved from the first night induction wing to B-wing on 8 August and then eventually to D-wing, where he settled from the end of September until the end of February 2006. He attended the chapel regularly and built a firm friendship with a fellow Iranian prisoner on his wing.
16. On 29 September, the man had a medical appointment to discuss his epileptic fit and the possibility of a referral to investigate the matter further. The following was noted in the man's medical record: "Says feels occasionally depressed and thinks about self-harm, says does not want to commit suicide. Says never wants to try again (cut wrists)".

17. During this appointment, the man said that his major concern at that time was the welfare of his little boys. A note was made that there should be an urgent referral to the community psychiatric nurse. However, there was no record of such an appointment taking place in his medical file.
18. On 10 October 2005, the man appeared at crown court and was formally charged with an offence of wounding with intent to cause grievous bodily harm and another offence of common assault. He was remanded back to Durham prison.
19. A nurse in the reception area of the prison assessed the man on his return from court and was concerned about his mental state. The nurse approached the residential manager for D-wing. The residential manager asked for the man to be brought to his office so that he could determine for himself whether he needed to be subject to self-harm monitoring and support measures (the F2052SH procedure then in force at Durham).
20. The residential manager told my investigators that he recalled how upset the man was about the welfare of his children. He was frustrated about the lack of information available to him. The residential manager placed the man on self-harm monitoring, which meant that staff had to make contact with him once during every part of the core day, once in the morning, afternoon and evening. They also had to observe him randomly during the night. He was prescribed a sedative for that evening and a referral was made to the mental health team.
21. Following a request from the chaplaincy, a probation officer met with the man on 11 October. The probation officer had only been qualified since the middle of September 2005, around a month before meeting the man. During interview, the probation officer told my investigators that he “distinctly recalled” the details of that meeting. The man was concerned about the welfare of his children. He wanted the probation officer to establish if his children were still in foster care and whether his wife had access to the children. Following their discussion, the probation officer contacted Social Services on the man’s behalf to begin his enquiries.
22. Within the required timescales, a review of the man’s self-harm monitoring took place on 13 October. Those who attended decided to continue the procedures. The residential manager said that he had daily contact with the man throughout this period. He described the man as a deep and emotional prisoner, who was often tearful when speaking about his children.
23. On 14 October, a doctor assessed the man’s mental health and changed the anti-depressant medication that he was taking. She also referred him for an Electro-Cardiogram (ECG) to investigate rapid heartbeats that he had been experiencing.
24. During a further self harm case review on 24 October, staff recorded that the man “feels much brighter since the medication has changed”. Staff did not feel it appropriate to change the monitoring arrangements following this review.

25. Despite the positive review, the next day an entry was made in the man's monitoring form that he had suffered a panic attack in his cell. He had rung the cell bell and when staff attended they discovered him in his cell repeating the words, "I just see the blood." He explained to staff that he had been thinking about his offence and his children going into care and this is when the panic attack came on. The officer who answered the cell bell reported the man's panic attack to the residential manager. The man told the officer that he would be "okay now" and the officer recorded that he had seemed to calm down. The officer asked the man's cellmate to alert staff if there were any further signs of panic.
26. During a visit on 26 October, the man accused an officer of bullying him by mispronouncing his name and continuing to do so for three months. On the same day, the man was invited to a Child Protection Review to discuss his children going into care. He was visited by his social worker the next day. Following the social worker's visit, the man asked to see a probation officer for information about father/child visits in prison. The probation officer recorded that the man was still concerned but "satisfied that his children are okay".
27. The man was taken off the F2052SH self-harm monitoring procedures on 31 October. He told staff that he felt much better since his change of medication. He was also pleased to have information about his children from Social Services and felt that this made him better able to "cope".
28. The residential manager continued to work on D-wing throughout the time that the man was on self-harm monitoring. They spoke daily during that time and got to know him well. Commendably, when the residential manager heard that Social Services had decided to return the man's children to the custody of their mother, he was concerned about how the news might be received. On 3 November, he called a multi-disciplinary team together, including staff from probation, chaplaincy and the Safer Custody Team, to discuss how the news should be broken. The probation officer told my investigators that Social Services were going to visit the prison to tell the man personally why the decision had been made. However, they changed their mind and said that they would not attend. It was decided that another member of the the prison's probation team should break the news to him. She had been working alongside the newly qualified probation officer in delivering the man probation services. The man was not happy about the decision, as he was apparently concerned for his children's safety in the care of his wife. However, despite the staff's concern, he assured them that he did not have any further thoughts of self-harm. He agreed that he should stay on D-wing and that he would speak to staff if he needed to.
29. On 4 November, the female probation officer prepared a statement about the man as a contribution to the Child Protection meeting. The man also prepared his own statement outlining in detail his concerns about his children's welfare. In the statement, he said that he did not want his children to be left with strangers, but that if Social Services decided permanently to return the children to their mother he would like to see the reasons in writing. He wrote: "Being in prison will not last forever and when I am out of prison, I will fight for my rights to have my

children back, no matter how long it will take or how hard it will be. I believe I have always been a good father to them and I miss them so much.”

30. The man did not attend the Child Protection meeting on 8 November and he was not represented when it took place. No minutes for the meeting were on his records. When asked, the probation officer told my investigators that Social Services would not routinely send in minutes of every Child Protection meeting to enable staff to pass on the findings to the prisoner concerned.
31. The man had a psychiatric assessment on 8 November for his criminal trial. The man had reported “no ongoing suicidal thinking”, although he had said that he was experiencing “ongoing insomnia and a degree of ongoing poor appetite and reduced energy”. He told the psychiatrist that these symptoms had improved while he had been in the care of Durham prison. Regarding the man’s level of risk to others, the psychiatrist concluded that, “despite the fact that this man has no major abnormal traits within his personality ... he would have to be regarded as high risk of perpetuating further such incidents in relation to his relationship with his wife until such times as he has made a full adjustment. It is my view that this could take between 12 and 18 months.”
32. On 20 December 2005, the man pleaded guilty to the offence of wounding with intent to cause grievous bodily harm and a secondary offence of assault. He was returned to Durham to await sentencing. In the meantime, he got a job as the chapel cleaner. When a vacancy arises in the chapel, prison staff are asked if there is anyone who should be nominated to fill what is a coveted position. The lead chaplain remembered that staff were keen to employ the man because he was well known to staff and attended the chapel regularly. It would have been a great privilege for the man to have worked in the chapel as it is a mark of staff’s trust.
33. The man remained keen to see his children. However, he was told on 5 January 2006 that his wife refused to let the children visit him in prison. In his wing history sheet, an officer recorded that he “appears to have taken the news quite well”.
34. The man’s community probation worker prepared a pre-sentence report for the court. (The pre-sentence report provides the judge with the circumstances surrounding the offence, background information about the prisoner and the prisoner’s risk of re-offending. The judge will take this information into consideration when deciding what sentence to impose.)
35. In preparation for her pre-sentence report, the probation worker met with the man while he was on remand at Durham, liaised with his social worker regarding his children, and spoke to the local Police Public Protection Unit. After gathering this information, she concluded that the man was minimising his role in the serious and violent offence that he had committed. With this in mind, she assessed him to be “a high risk of serious harm towards a known adult and a medium risk of serious harm to the public”. She suggested that the court should consider whether “the significant risk test is met”. The judge felt that the man did pose a risk of serious harm to the public, specifically his wife. In light of this, he was sentenced to an Indeterminate Sentence for Public Protection (IPP) with a

minimum period in custody of three years to include the time he had already spent at Durham.

36. When explaining the sentence on 31 January 2006, the judge said that the man would have received a six year sentence if he had not been deemed a 'significant risk' to the public. Unfortunately, this was misunderstood by the court clerk to be the man's sentence and was entered into his court documentation that was taken back to HMP Durham. Each prisoner has an individual card that is placed outside their cell, with the prisoner's name, location, prison number and details of sentence. When my investigators were collecting the man's records, they noticed on his cell card that someone had written that he was serving a six year sentence. This had remained uncorrected at the time that he died, nearly six months after sentencing.
37. Much confusion surrounded the man's indeterminate sentence. On the day after his sentencing hearing his solicitor, wrote to him to confirm that he had received "an indeterminate sentence totalling six years". In fact, an indeterminate sentence is a life sentence. A prisoner must serve a minimum amount of time before a Parole Board will assess whether they are a risk of serious harm to the public. If the Parole Board is satisfied that the prisoner no longer poses such a risk, they should be released. The judge suggested that the man should serve a minimum of three years (including the time he spent on remand). The newly qualified probation officer who had worked with the man in prison realised the solicitor's mistake and rang to discuss the matter. The probation officer told my investigators that, after some consideration, the solicitors agreed that a mistake had been made and said that an apology would be sent to the man. No such letter was found on the man's files or in his possessions.
38. The man had pleaded guilty to the two offences. Both of these offences meant that he was eligible for consideration under the 'significant risk' test and for an indeterminate sentence for public protection. Nevertheless, the man had not been prepared for this possibility. The probation officer was clear that the man did not understand his sentence on his return from court. He thought that he had received a six year sentence and was devastated to learn that his sentence could be up to 99 years. (A prisoner serving an indeterminate sentence cannot be released unless he is granted release on licence by the Parole Board. Accordingly, there is always a possibility that the prisoner may never be deemed suitable for parole and his sentence becomes the equivalent of life – 99 years.) The probation officer explained to him that he had no guaranteed release date for his sentence and that he would have to work towards reducing his risk over the next two and a half years. Understandably, the man found it difficult to accept the possibility, however slight, that he might never be released from prison.
39. In order to work towards his release, the man needed to be placed in a prison with a lifer unit. Durham's Lifer Manager, went to visit the man on 2 February because he had been told that he was still confused about his sentence and feeling "fragile". At interview, the Lifer Manager recalled his impressions of the meeting: "... he came across as a very mild mannered individual, apprehensive, but underlying it all I recall discussions about the most important thing being his

children and whether or not he would lose contact with the children in the fullness of time.”

40. The Lifer Manager said that he remembered the man being most concerned about the “long term impact” of the sentence, once he had understood how the sentence worked. At the time that they met, the man was worried about how his sentence would affect his access to his children. The Lifer Manager reassured the man that the type of sentence that he had received was unlikely to prevent him from having access. The Lifer Manager thought that Social Services would be more concerned with his wife’s attitude to him having access, rather than the fact he had received a sentence for public protection.
41. In the meantime, the man’s concerns about his children continued. Another Child Protection Review was held on 3 February. A solicitor represented the man at the meeting but it is minuted that she had not been briefed by him.
42. On 6 February, the man was put on a waiting list to be transferred to HMP Manchester’s lifer unit where he could begin working towards his release. In line with normal procedure for prisoners who have received life sentences, he was interviewed on 10 February to see how he was adjusting to his sentence. He was reportedly “coping ok” with “no thoughts of suicide”.
43. According to other prisoners on his wing, the man never came to terms with his sentence or missing his children. In an effort to address the confusion about how indeterminate sentences worked, the Lifer Manager arranged to come over to the enhanced wing where the man lived to make a presentation to prisoners. Other prisoners, interviewed by my investigators, thought that this session was helpful to a point. They believed that there were questions that prison staff did not know the answer to, because the practicalities of the system had not been thought through.
44. The man worked from Monday to Friday as the chapel cleaner. Reverend The lead chaplain described him as “very quiet and serious, but also someone who you could joke with and who was quite funny. He was pleased to be working in the chapel, and was a good worker.” He also completed several courses in Moral Issues and one in Driving Awareness.
45. As chapel cleaner, the man automatically qualified to live on F-wing, regardless of the fact that he had not earned enhanced status under the prisons earned privileges scheme. It was not until 10 April 2006 that he applied successfully for enhanced status. The man’s good friend told my investigators that the man wanted to have his own room on F-wing. Prisoners who arrive on the enhanced wing are automatically put into a shared cell, subject to risk assessment. It is then up to the prisoners to apply for a single cell. Prisoners who respect the regime are more likely to get a single cell. Not all prisoners like to be by themselves, but the friend told my investigators that it was important for the man to be by himself. He said that the man’s cell was not the most sought after cell on F-wing and he was concerned about him living there. At one point, the man’s friend offered to share a better cell with the man rather than let him live in the cell

he had been given. The man refused that offer and explained to the friend that he liked to be by himself for privacy.

46. On 15 May, the man was put in the segregation unit overnight because a length of cable had gone missing from the chapel. It was discovered the next day that a workman had removed the cable and its disappearance was nothing to do with him. Although in retrospect the decision to segregate the man might appear heavy-handed, it is well-documented and he seemed to take it in his stride, returning to work the next day as usual.
47. When a prisoner has been sentenced to an indeterminate sentence for public protection, their probation worker must prepare a post-sentence report for the establishment within four months of sentence. The report is a way of building on the pre-sentence assessments and highlighting any particular needs that can be addressed in the sentence plan. The post-sentence report, prepared on 2 June, recognised that the man “has clearly attempted to address” his lack of empathy towards the victim of his offence. However, he was still assessed as posing a high risk to a ‘known adult’ (his wife), and the risk he posed to his children was still being assessed by Social Services. The report concluded: “[the man] is clearly an intelligent and thoughtful adult. Given my assessment in regard to his victim empathy, I would acknowledge, however, that he is attempting to address the critical issue and I consider it to be vital that he continues to do so.”
48. In June 2006, following a Child Protection conference to which the man was invited but did not attend, his children moved to London to live with their mother. The man told friends that he was happy that she was looking after them. He said that he had come to terms with the fact that they would be safer in her care than the charge of a stranger.
49. A fellow prisoner on F-wing said that the man would often confide in him. During interview, the F-wing prisoner said that the man felt “over certainly the three weeks leading to his death that he’d been let down by certain members of the Prison Service, the Probation Service, it was stressed very clear to me.”
50. The prisoner said that the man told him he had been thinking of killing himself about three times over the two weeks prior to his death. This prisoner had previously been trained to support prisoners who were going through a particularly low time. He was confident that he would recognise whether the man was serious about taking his own life. He did not pass on the man’s comments to any other prisoner or member of staff because he did not think that he was serious. He described the man as being as “happy as Larry” in the 24 hours before he died. At the time, the prisoner thought that he had pulled the man through his difficult time.
51. In the week that he died, the man was studying a course in Social Awareness. The course was being led by a Programmes Tutor, responsible for researching, developing and delivering programmes for staff and prisoners located on F-wing. Social Awareness was a pilot course being run by the Programmes Tutor for the first time. He selected prisoners according to whether they were likely to participate well, be patient with any teething difficulties arising, and who would

provide useful feedback to enable further development of the course. The Programmes Tutor identified the man as someone who fulfilled these criteria and asked if he would participate in the course. The man agreed to attend voluntarily, along with eight other prisoners.

52. When it is fully developed, the course is intended for prisoners who are due to be released within a matter of months. (In practice, only two of those prisoners who took part in this first course were due for release within about a month.) Its aim is to introduce prisoners to skills and resources they may require in the community. Topics included how to access community healthcare, budgeting and cooking a meal for a family of four. As an introduction, the class were asked to reflect on their responsibilities, to themselves, to others and to society. Social Awareness was identified by the Lifer Panel as an area that the man should try to develop in his efforts to be recognised as suitable for release.
53. The man took notes during the class. He wrote that he wanted to “start a fresh new life ... be successful and live a happy life.” During the module entitled ‘Roles and Responsibilities’, a copy of the UN Declaration of Human Rights was distributed. The man circled Article 7: “Everyone should be treated in the same way, and laws should apply equally to everyone.” He also circled Article 30, asserting that no one can destroy the rights set out in the Declaration.

5 July 2006

54. The man awoke in the morning and collected his breakfast. His good friend knocked on his door as normal, and said that the man appeared “fresh”. He had showered and put on a new t-shirt. The man’s friend had the impression that he was feeling better than he had done over the last few days.
55. Wednesday 5 July was the third day of the man’s Social Awareness course. That morning, the class concentrated on Alcohol Awareness. Although the man did not drink, he told the Programmes Tutor that he found the class useful to understand the actions of others under the influence of alcohol.
56. Most of the other prisoners in the group described the man as fine that morning. They recalled him engaging with the course despite the fact that he did not drink alcohol. Another prisoner on the Social Awareness course, said that the man seemed “quite chatty on the course and was open to questions and answers”. This prisoner said he knew the man quite well, although he said that because he was quiet generally it was not always easy to tell when he was down. The Programme Tutor described the man’s participation in the course that week as “excellent”. He did not notice anything unusual in his behaviour.
57. One of the other prisoners on the Social Awareness Course had a job on the servery and left the course early to start his work. He was stationed in a position just past the servery, with a list of prisoners’ names, and was taking orders for dinner the next day. The man left the class at around 12 noon. The officer responsible for co-ordinating the wing kitchen had a record that the man had placed his food order but did not specifically recall seeing him that lunchtime. The prisoner from the course remembers seeing the man that lunchtime. He said

to him, "See you later", and the man replied, "Yes". It is likely that the prisoner was the last person to speak to the man. He took his lunch into his single cell. No member of staff recalls seeing the man after that time. During the lunchtime period, prisoners are locked in their cells. No one spoke to the man during the lunchtime period.

58. At around 1.40pm, an officer had begun to unlock prisoners on the second landing of F-wing, where the man's cell was located. The standard procedure for unlocking prisoners on F-wing is to turn the key, flip the latch on the outside of the cell door and push the door ajar. My investigators were told that officers on F-wing do not speak to every prisoner because they are trusted to make their own way to work. Once all of the doors have been opened and a period of five minutes has elapsed, the officers will check that everyone who has work or a course has left their cell. The officer opened the man's cell door and left it ajar. He did not look into the man's cell or speak to him at that time.
59. A fellow prisoner on F-wing was employed as a cleaner on the wing. Part of his role was to deliver fresh laundry to cells. He did his laundry round on that Monday lunchtime as usual. When he reached the man's cell, he could see that his door was ajar. He thought the man might be in the cell, so he opened the man's door further in order to hand him his laundry. The cleaner dropped the laundry that he was carrying. A probation officer was standing nearby waiting for prisoners to arrive for his afternoon class. The class was due to take place in the classroom adjacent to the man's cell. The cleaner looked at the probation officer. They both looked into the man's cell together. The probation officer said that he saw the man hanging from the bathroom door. At that stage, he thought that the man might have been dead.
60. The probation officer and the cleaner ran together to the wing office, shouting for assistance. A senior officer and the officer in charge of the kitchen were working in the wing office. The probation officer was shouting "there's a hanging". The two officers made their way immediately to the man's cell. On their way, the kitchen officer shouted "Staff! Staff!" in order to get colleagues to come to their assistance. The probation officer went with the officers to the cell. Then he left the cell and returned to the classroom to allow prison staff space for resuscitation efforts. (The probation officer is not trained in first aid or the emergency response.) The cleaner found the other cleaners on the wing. All of the prisoners on the wing were asked to go to the television area together for the duration of the response effort.
61. The cell door was open. The kitchen officer and the senior officer made their way to the bathroom door. The ligature was made from bed sheets. The senior officer supported the man's weight. The kitchen officer was behind the senior officer and she saw the senior officer's ligature knife in the back of her response belt. Rather than retrieve hers from behind her, the kitchen officer grabbed the senior officer's ligature knife. She tried to cut the ligature with the senior officer's ligature knife, while supporting some of the man's weight with the senior officer.
62. The officer who had unlocked the man's cell door had heard the kitchen officer call for assistance. He was still unlocking cell doors on the second landing and

had progressed around the corner. He made his way immediately back to the man's cell to find the two officer trying to support the man's weight. He also lifted the man's weight to enable the kitchen officer to cut the ligature more effectively.

63. By this time, another officer had made her way to the man's cell from the fourth landing. She had removed her anti-ligature knife from her belt before she reached the cell. She jumped onto the bed and cut the ligature with her knife. Another officer also arrived at the cell to assist.
64. An officer had been unlocking prisoners on the third landing when he heard the kitchen officer call out for "staff". He ran to the cell and arrived as the man was being placed on the bed. He asked if there was anyone who was trained in first aid, but soon realised that first aid was underway. He stepped out of the cell, because he felt that there were enough staff in the cell already and he could be of no further assistance. An officer on the landing outside the cell started to walk to the telephone to call for assistance, but realised that he had a radio on him although he had not logged on to the prison radio system. He turned on his radio and made the following call: "Hello. Urgent situation. Hotel One, Oscar One. We have a hanging."
65. The officer who radioed understood that for emergency situations he should use the term 'urgent message'. Hotel One is used to summon an emergency medical response from the healthcare team. Oscar One refers to the Orderly Officer who is in charge of the operation of the prison throughout a shift. Officer Parker said that staff had just finished their lunch break. The radio system was on 'talk-through' which meant that everyone in the prison could hear his radio message. When the officer who radioed looked back into the cell, it was his impression that the situation was serious. He made a further radio call, around five to ten seconds after the original one: "We need paramedics ASAP!" Upon hearing this, the Communications Room ordered an emergency ambulance. The call was recorded as being made at 1:57pm.
66. Four officers in the cell moved the man to his bed to commence Cardio-Pulmonary Resuscitation (CPR). The senior officer recalls that the man was pale in colour and showed no signs of life. She described his neck as "floppy" as he was moved from the bathroom door to the bed. The senior officer carried an old resuscitation aid in her belt. It was issued to her "some years ago". She placed the small airway into the man's mouth to start mouth-to-mouth resuscitation. The kitchen officer began chest compressions. Staff heard the man make a noise and thought he had started to breathe. The kitchen officer felt for a pulse but could not find one. Following the noise, another officer shook the man to get a further response. When there was no response, he took over the mouth-to-mouth resuscitation, while the kitchen officer continued with the chest compressions.
67. The senior officer responsible for F-wing arrived at the cell in the meantime. He stood at the cell door and suggested that the man should be moved to the floor to improve the chest compressions. Officers followed his instruction. Another officer took over chest compressions.

68. The Hotel One duties are allocated to nurses on a rota basis. If a healthcare staff member is Hotel One, they must respond to all emergencies. The nurse who was Hotel One that day was near the office on the healthcare centre at around 1:45pm on 5 July when the radio call came through. Her manager was nearby at the time and also heard the radio call. The manager grabbed the emergency bag and gave it to the Hotel One Nurse. She instructed another nurse to attend the emergency with the Hotel One Nurse. The two healthcare staff went immediately to F-wing, carrying the bag. It took approximately two minutes to get there from the healthcare centre.
69. On arrival, the Hotel One Nurse found the officers attempting resuscitation. She checked his vital signs and took over from the officer performing mouth-to-mouth resuscitation. She used an ambubag and oxygen.
70. One officer and the senior officer found themselves in the bathroom, observing the nurses' efforts at resuscitation. They did not exit the cell because they felt that they could not get past the nurses without disturbing them.
71. The nurses told the clinical reviewer that there were no signs of life when they arrived at the man's cell. A few minutes later, the nurses' manager arrived at the man's cell with the duty doctor for Durham prison that day. The defibrillator was applied by the doctor. The defibrillator reading showed no signs of life. This meant that it was not appropriate to shock him.
72. The paramedics arrived at around 1:59pm. They followed their resuscitation protocol without success. The duty doctor pronounced the man dead at 2:25pm.

Staff Debrief

73. Staff who had assisted with the resuscitation attempts had gathered in the senior officer's office. They were told immediately that the man had died. The kitchen officer and the officer who made the radio call went to the cleaner's cell to inform him and check how he was feeling. The prisoners had been locked in their cells while the paramedics were attempting resuscitation.
74. Staff were asked to make statements that afternoon. Officers involved in the resuscitation attempts were given the opportunity to go home. Healthcare staff went back to their duties in the healthcare centre. The nurses' manager checked the welfare of everyone who had attended the man's cell, apart from those that had discovered him, the probation officer and the cleaner.
75. A staff debrief took place at 4:30pm. All staff who attended said that it was useful to piece together what had happened. The officer who used the radio was surprised not to have been invited to the hot debrief, despite offering to attend. He felt he might have had some helpful information about the immediate response, given that he had made the radio call.
76. A further critical debrief was held by the prison's Care Team on 27 July, three weeks after the man's death. The debrief was not mandatory but was well-attended. This gave staff another opportunity to express any anxieties about the

response. The minutes of this meeting are confidential to encourage open discussion. My investigation team has not asked to see these minutes, but is aware of their existence.

Family contact

77. As one of the prison's trained Family Liaison Officers, the senior officer was initially approached by senior management to contact the man's family. Once she had explained how involved she was in the response efforts, it was agreed that it would be inappropriate for her to be the family liaison officer in this case.
78. The Deputy Governor contacted the Iranian Embassy to notify them of the man's death. The Embassy acted as liaison with the man's mother who lives in Kuwait. Unfortunately, his mother was not directly contact by the embassy and learned of her son's death through friends. As soon as contact had been made with her, arrangements were made by the Safer Custody team for her to fly to Britain and see her son's body. The man's mother could not speak English, so a member of her family accompanied her and acted as a translator.
79. The man's wife contacted the prison and asked to visit the man's body and the cell where he died. The prison kept in regular contact with his mother and his wife, who both visited the prison. The prison also made the complex arrangements for the man's body to be flown back to the Middle East for his family to bury him.

I would like to commend the sensitivity and dedication of the Safer Custody Manager for excellent liaison in such a complex situation.

80. One of my office's Family Liaison Officers, was accompanied by one of my investigators at a meeting with the man's family during his mother's brief visit to Britain. The man's mother, cousin and wife were present. Understandably, they were unfamiliar with the criminal justice system and had many questions which I have endeavoured to answer during the course of this report.
81. The man had told his mother that he was "doing great and taking classes", and had said to her that he "just wanted to see my children". His mother sent the man photographs of his children and told my investigators that she was concerned that he had not received them. My investigators spoke with fellow prisoners on the wing who said that he did have a lot of photographs of his children in his cell with him. When the investigator collected his records, she noticed that there were many photographs of his children and friends.

ISSUES

The Clinical Review

82. The clinical reviewer was commissioned by Durham and Chester-le-Street PCT to examine the man's medical care while he was in prison. The clinical reviewer looked at his medical file and compiled a chronology of events. He also reviewed the appropriateness of efforts at resuscitation.
83. The clinical reviewer concluded that the man's "problems were well recognised by the clinical and mental health teams". He added: "Latterly he displayed a very positive outlook and there were no indications that he intended suicide."
84. The clinical reviewer judged that the man had received "competent care" and there was nothing that the clinical team could have done to prevent his apparent suicide. He made no recommendations.

Was the emergency response appropriate and timely and could this have affected the outcome?

85. The man's cell door was unlocked by an officer at the end of the lunchtime period. In line with normal procedure, the officer did not try and speak to him, but left his door ajar and continued to unlock other prisoners on the same landing. The officer told my investigators that it is normal practice on F-wing not to check on the prisoners when unlocking them. It is a part of the accepted regime, as a sign of trust for the prisoners who have earned enhanced status. My investigators spoke to other members of staff who work on F-wing. They agreed with the officer that it was not practice to speak to prisoners when unlocking on F-wing, and this was to show trust that they could make their own way to work or classes. (Neither F-wing nor the rest of the prison has a written policy about not speaking to prisoners when unlocking their cell door.)
86. If the officer had looked into the man's cell when he unlocked it, it is likely that he would have discovered him hanging from his bathroom door. National Prison Officer training instructs staff that the door should always be opened to establish the whereabouts of the prisoner before moving to the next cell. During interview, the officer said that he had just walked around the corner, past the probation officer, when he heard shouting that the man was hanging. He estimated that 30 seconds had passed since he had unlocked the man's door. Although it may not have changed the outcome in this case, it is good practice for staff to check prisoners when unlocking them.

The Governor should remind staff that each time they open a cell door, they must check the whereabouts and welfare of the prisoner or prisoners in the cell at that time.

87. The man was discovered by a fellow prisoner on F-wing. Staff were immediately alerted and first efforts were commenced in a timely fashion. One officer radioed for assistance because he happened to have a radio on him at the time. He was not logged on to the radio system, but this did not affect the timing of his radio

call. My investigators were told by Durham's Safer Custody team and by the healthcare staff that there is a code system in operation at Durham. The code system communicates what type of emergency has occurred without explicitly referring to what has happened. (This is to prevent prisoners and others from inappropriately over-hearing the nature of the emergency.) Healthcare staff told my investigators that staff always used the code system. It is unfortunate that the officer used the phrase "we have a hanging" when the radio system was on a setting that meant that everyone near a radio would have heard him. However, I am satisfied that this was a natural reaction to difficult circumstances and, on this occasion, had no negative impact on the situation.

The Governor should ensure that all staff are familiar with radio procedure and the emergency code system.

88. At the time of the man's death, staff were not required to carry anti-ligature knives. I commend Durham for having in place a local policy that ensured the ready availability of anti-ligature knives among the staff who responded to this emergency. Since November 2006, it has become a national requirement for all frontline Prison Service staff in closed prisons to carry anti-ligature knives.
89. It was by chance that the senior officer had a resusci-aid with her at the time of the first aid response. The inexpensive plastic mask prevents both staff and prisoners from the transmission of infectious diseases from body fluids. However, at present officers are not routinely issued with this piece of first aid equipment.

The Governor and the Head of Safety and Decency should consider issuing resusci-aids to staff as standard.

90. Healthcare staff arrived at the man's cell promptly and continued with the resuscitation efforts, although it was their professional impression that the man was clinically dead at that time. The clinical reviewer agrees that the team were correct to do so.
91. The emergency response to discovering the man's death was quick and competent. It is very unlikely that any of the issues discussed would have changed the outcome.

Did the man's sentence contribute to his mental state when he died?

92. The man was serving an indeterminate sentence for public protection (IPP). He had pleaded guilty to the two serious charges against him, both of which may qualify the offender for a public protection sentence. However, it seems that he had not been told about these sentences and how they worked either by staff at the prison or by his solicitor. Indeed, he did not understand that he had received an IPP sentence when he was at court. It was only after several misunderstandings, involving the court clerk, his solicitor, the Prison Service and the man himself that his Probation Worker explained to him the nature of the sentence that he had received. It appears he was devastated by the 'life' component of the sentence. Nevertheless, the Lifer Unit at Durham made efforts

to ensure that he had understood the sentence and its implications. Durham's Lifer Manager visited the man personally because it was thought that he was fragile and needed further explanation of his sentence.

93. When he realised that the confusion was more widespread, the Lifer Manager made a presentation to the prisoners on F-wing about how indeterminate sentences work. This is to be commended. Yet when my investigators spoke to prisoners who attended the session, they still seemed uncertain of their sentence, although they were at pains to point out that they did not believe that staff at Durham were withholding information from them. The feeling was that it was unfair to prisoners, because the system was not able to cope with the number who had been given an indeterminate sentence. Prisoners were unable to obtain the necessary transfer to prisons where they could begin to work to address their offending behaviour and towards parole.

The Lifer Manager made a presentation to the prisoners on F-wing about how indeterminate sentences work. This was good practice that I commend.

94. My investigator spoke to the project lead at the National Offender Management Service (NOMS) who has been taking forward a project looking at the effect of short tariff indeterminate sentences on the lifer estate as a whole. Following their conversation, the investigator was forwarded a list of the 79 prisons in which the 1,359 prisoners with IPP sentences were being held on that day (12 September 2006). According to these statistics, Durham was holding 45 prisoners at that time, the fifth largest group of prisoners with IPP sentences in the prison system.
95. In order to persuade the Parole Board that they can safely be released on licence, prisoners on IPP sentences should complete courses identified as part of their sentence plan. However, they must first move from a local prison like Durham to a lifer unit before they can start that plan. Delays in prisoners transferring to lifer units are leading to delays in sentence completion and a backlog of prisoners trying to get through the system. The NOMS project lead told my investigator that the problem is not confined to the North East of England. It is a national problem, and – given the number of IPP sentences imposed by the courts – one that is growing. I understand that the number of IPP prisoners is growing by around 100 each month.
96. At the time of his death, the man was still a way down on the waiting list (he was number 27) for a transfer to the lifer centre at HMP Manchester. The Lifer Manager was in no position to say how long he thought it would take before the man would have been transferred, although he estimated his transfer was still “months” away. The man had completed a number of courses at Durham. He had earned the respect of staff through his behaviour. He had served nearly a year of his three year tariff, but had not even started to work towards his release because he was stuck at a local prison, unable to move on because there were insufficient places in the lifer estate.
97. The man was also desperate to see his children. However, despite working hard at Durham, and impressing staff with his conduct, he could realistically have had

no release date in mind, and no date when he might be reunited with his children. In fact, the man had been told by the prison probation officer that, with continued good behaviour, he was likely to be released sooner than most IPP prisoners. However, at the Lifer Manager's presentation on the IPP sentence, he had indicated that the minimum term that a prisoner should expect to serve, given the current system, was five years. The man told his fellow prisoners that he felt his human rights were being violated. He said he would rather be serving a sentence in Iran, from where he had fled in persecution, than serving an IPP sentence in Britain.

The National Offender Management Service should review the number and location of prisons that are able to work with those serving an IPP sentence with a view to increasing such places as quickly as possible. Delays in transferring someone to a suitable prison where they can start to work towards their sentence plan targets must be minimised.

Were there any missed signs that the man might take his life?

98. Ten months before he died, the man had been subject to F2052SH monitoring for a period of three weeks. He had seemed okay in the intervening months after the F2052SH was closed. The man appeared to be in his usual spirits to the staff on F-wing. In the weeks leading to his death, it would seem that the man only told one friend that he was considering suicide. That friend said that he would have felt comfortable approaching staff had he thought that the man was serious about taking his life. It was his impression that the man was depressed, but that he was not going to harm himself. The friend had received training in dealing with depressed prisoners in need of support. His opinion was, therefore, a considered one.
99. On the morning that the man died, he actively participated in a course and he ordered his meal for the next day. He had spoken with his friends that morning, as usual. If anything, he appeared "fresher" to them than normal.
100. Although it has been a feature of many of my investigations (and is reflected in the wider literature) that someone contemplating suicide may appear comfortable, even elated, having taken the decision to do so, I agree with the clinical reviewer that staff cannot be said to have missed signs of the man's suicidal intent. His death came as a surprise to all of them, and I do not think it could have been predicted.
101. In retrospect, the nature of the man's offence, the fact that he had previously attempted to harm himself, and the uncertainty over his sentence were all risk factors. However, none of these were such that his actions over the lunchtime of July 5 2006 could reasonably have been anticipated.

RECOMMENDATIONS

I have made two commendations, as follows:

I would like to commend the sensitivity and dedication of the Safer Custody Manager for excellent liaison in such a complex situation.

The Lifer Manager made a presentation to the prisoners on F-wing about how indeterminate sentences work. This was good practice that I commend.

I have made four recommendations:

The Governor should remind staff that each time they open a cell door, they must check the whereabouts and welfare of the prisoner or prisoners in the cell at that time.

The Governor sought clarification of this recommendation. A notice to staff will be issued.

The Governor should ensure that all staff are familiar with radio procedure and the emergency code system.

This recommendation was accepted and a Governor's notice to staff was issued in January 2007 to remind staff of the use of radio procedures in medical emergencies.

The Governor and the Head of Safety and Decency should consider issuing resusci-aids to staff as standard.

This recommendation was accepted. Staff are to be issued with resusci-aids following half day "Heart Start" training sessions, which are delivered on a rolling programme.

The National Offender Management Service should review the number and location of prisons that are able to work with those serving an IPP sentence with a view to increasing such places as quickly as possible. Delays in transferring someone to a suitable prison where they can start to work towards their sentence plan targets must be minimised.

The National Offender Management Service accepted this recommendation. The number of prisons who can accommodate prisoners serving IPP sentences has been increased as an interim measure while a wider review of the management of IPP sentences gets underway.

Since this report was first drafted, the IPP sentence has come under much media scrutiny. In July 2007, a prisoner has successfully argued in the Court of Appeal that his indeterminate sentence was unlawful. His case rested on the fact that he could not be considered for release because the prison that he was in did not offer the course he needed to complete, before being considered eligible for parole. The Court of Appeal ruled there "was a general and systemic legal failure" in the delivery of indeterminate sentences. The government was granted a stay on the ruling,

pending an application for permission to make an appeal. I await the outcome of this legal challenge with interest.