

**Investigation into the circumstances
surrounding the death of a man
who was a prisoner at HMP Durham in November 2006**

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

July 2007

This is the report of an investigation into the circumstances surrounding the death of a man at HMP Durham in November 2006. At approximately 11.15am on a Wednesday morning in November, he man was found hanging in his cell. The man was 37 years of age.

I offer the man's family and friends my most sincere condolences for their loss.

The investigation was carried out by two of my investigators. As in all my investigations, a key aim was to make sure the family had the opportunity to raise any concerns. My Family Liaison Officer contacted the man's family, and I very much appreciate their willingness to discuss his death so soon after their bereavement.

Again in line with my procedures, I commissioned an independent Clinical Review of the management of the man's health needs while he was in custody. I am most grateful to the doctor who carried out this review for his assistance.

I would also like to thank the Governor, Deputy Governor, and staff at Durham for their ready help and co-operation during the investigation. I am especially indebted to the liaison officer who ensured that the investigation went as smoothly as possible.

My report includes three recommendations about healthcare records and basic life support training. I also note that the prison has already increased the provision of life saving equipment, and that it is more readily available, and that a previous recommendation I have made about first aid equipment has been implemented.

The man had been sentenced the week before he died to two months imprisonment for contempt of court. He had harmed himself during a previous sentence, but this was not known to Durham staff because past records were not available. This is a significant weakness in systems for ensuring the safety of prisoners, but one unlikely to be overcome until all records are kept electronically.

During the few days he was in custody on this occasion, the man completed a detoxification programme. Staff did not detect any signs that he intended to harm himself again.

This version of my report, published on my website, has been amended to remove the name of the deceased and the names of staff and prisoners involved in the investigation.

Stephen Shaw CBE
Prisons and Probation Ombudsman

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CONTENTS

Summary	4
The investigation process	5
HMP Durham	6
Key findings	8
Issues	16
Conclusion	18
Recommendations	19

SUMMARY

The man at the centre of this report was arrested on a Thursday in November 2006 for contempt of court. He had breached an injunction imposed after he committed public disorder offences. He was sentenced to two months imprisonment and taken to HMP Durham later in the evening. The man was familiar with the prison and its regime as he had been in custody there before.

The man went through the reception screening interview which identified his dependency on drugs. He was assessed as low risk of harm to others and himself. Opening an Assessment, Care in Custody and Teamwork (ACCT) document was not considered appropriate as there was no apparent risk of suicide or self harm.

He was transferred to E wing, the induction wing, where he successfully completed a five day drug detoxification programme. Six days later, the man was moved to a shared cell in a normal residential wing, B wing, and expressed no anxieties about the move.

His cell mate was out of the cell when the man arrived. When the cell mate returned, he discovered the man hanging from the top bunk. Prison officers, nurses and the prison doctor attempted cardio pulmonary resuscitation (CPR), until the paramedics took over. There were no signs of life and the doctor certified him dead at 11.45am. He was 37 years old.

The man had harmed himself during a previous sentence, but this was not known to the staff who reviewed him when he was received into custody. However, I conclude that, even if staff had known of his past self-harm, its relatively minor nature and the absence of any signs of distress on this occasion make it unlikely that any different actions would have been taken.

INVESTIGATION PROCESS

1. The investigation began in November 2006 when my investigators met the Governor, Deputy Governor, representatives of the local branch of the Prison Officers' Association (POA) and the Independent Monitoring Board (IMB), as well as the Healthcare Manager and the chaplain. My investigator explained the nature and scope of the investigation and the report handling process.
2. The same day, notices were issued to staff and prisoners announcing the investigation and inviting anyone with information about the man's death to make themselves known. My investigators subsequently interviewed 14 members of staff and spoke with two prisoners who had contact with him.
3. The investigators also contacted the HM Coroner for Darlington and South Durham, and the investigating police representative. The Coroner will be copied into this report to assist him with his inquest into the man's death.
4. On 9 December, one of my Family Liaison Officers, contacted the man's parents to find out what concerns they wanted the investigation to address. The family asked one question about why their son was allowed to keep his belt and shoe laces. They also asked to be kept updated with the findings of the investigation.

HMP DURHAM

5. Durham is a local prison, holding 981 men. The prison has an 'integrated' regime which means that all the prisoners are located together, regardless of their offence or vulnerability. There are three main residential wings. A, B and D wings are for sentenced and remand prisoners. The other wings serve specialist functions, including E wing which is the induction wing for new prisoners.
6. Her Majesty's Chief Inspector of Prisons, Ms Anne Owers, inspected the prison in September 2006 and commended the reception and first night arrangements. She reported that the procedures to support suicidal and self-harming prisoners had improved considerably, and she recognised that relationships between staff and prisoners remained good. Overall, she considered that Durham was an improving establishment which was developing its role as a local and community prison for the north east. Ms Owers highlighted two relevant areas for attention. The first was the need for more effective support for the most vulnerable prisoners. The second was to ensure that there are sufficient activities linked to resettlement opportunities.
7. The death of the man at the centre of this report was the tenth I have investigated at Durham since April 2004. Three of these were the result of natural causes and seven were apparently self inflicted.

Reception and induction

8. A Cell Sharing Risk Assessment (CSRA) is initiated by the front desk reception officer who completes the basic details. It is then handed to the first night centre staff in reception where a confidential interview is conducted. The document is then passed to healthcare staff. The CSRA is intended to provide consistent and continuing risk assessment and management relating to cell-sharing.
9. The initial healthcare screening concentrates on the prisoner's immediate well-being, their mental health, risk of self harm or suicide and any drug or alcohol withdrawal or detoxification issues.
10. Reception staff do not have access to a prisoner's past records. The prisoner is therefore the major source for the information at this stage.
11. All new prisoners are located on the induction wing. They have an initial meeting with staff, who complete the first section of the first night induction and initial assessment document, provide their induction programme and explain the prison regime. Prisoners are asked about any immediate concerns, such as disability, their offence and general well being.
12. The induction includes a further assessment, medical screening, and input from the education and offender management units. Prisoners are given a new reception pack, and telephone pin numbers and visiting arrangements are explained. The prisoner again has the opportunity to report any problems.

13. Insiders are prisoners who volunteer to work in the First Night and Induction wing and Reception, welcoming new prisoners and explaining the processes they will encounter in the early days of custody.
14. When prisoners have completed their induction, they are moved to one of the residential wings. Depending on available spaces and subject to any risk assessments, they can express a preference to move to a specific wing.

Drug support

15. The Counselling Assessment Referral Advice and Throughcare (CARATs) team provide a counselling service for prisoners who have a history of abusing drugs or alcohol.
16. The Addiction Team works with prisoners who are actively withdrawing from drugs and alcohol. They provide detoxification programmes, advise on harm minimisation and harm prevention, and treat blood borne viruses, particularly amongst new prisoners. A substance misuse nurse sees the prisoner the morning after their arrival to carry out an in-depth assessment and decide what treatment should be provided. Prisoners who need prescribed medication are referred to the substance misuse doctor. Referrals to other agencies are made, including the CARATs team and community drug services.

Suicide and self harm monitoring

17. In common with all prisons, Durham has implemented the Assessment, Care in Custody and Teamwork (ACCT) approach to helping and monitoring prisoners at risk of harming themselves. The key aims of ACCT are to create a safe and caring environment, to identify prisoners' individual needs, and to provide individualised care and support before, during and after a crisis.

Emergency codes

18. Emergency codes are used to summon staff to deal with a particular situation. Code Black indicates an incident involving a ligature, and Code Red is used for incidents involving substantial blood loss. Hotel 1 is the radio call-sign for the emergency response.

Fish Knives

19. So-called fish knives are specially designed for cutting ligatures. They are carried by all officers in front-line contact with prisoners.

KEY FINDINGS

20. The man was arrested in mid November 2006. Having been sentenced to two months imprisonment, he was taken to HMP Durham, arriving at 7.55pm. The escort document, which records events whilst a prisoner is escorted to and from police stations, courts and prisons, recorded no apparent concerns about him.
21. The reception officer on this day began her duty at 5.00pm. Normally she worked on E wing, the induction wing, but E wing staff are also rostered to work in reception because of their experience of dealing with new prisoners. The reception officer told my investigator that her recollection was that the man was one of the first prisoners she interviewed that evening. She went through the questions on the CSRA. She had no concerns about him sharing a cell, and he was recorded as a low risk prisoner.
22. The man signed local agreements, known as compacts, regarding his behaviour on the wing and use of the television. He said that he had no problems and confirmed that he had been in prison before so was familiar with the regime. The reception officer said that the man was pleasant and polite throughout the interview and she was not concerned about him. She said that he did not seem uncomfortable when he spoke and he answered all the questions confidently. The man then proceeded on to the next stage of the process which was to be seen by healthcare.
23. The healthcare nurse completed the man's assessment by asking a number of further questions. The man confirmed that he had been in prison before, and had no physical or mental health problems. He said he drank alcohol, but did not have a drink problem. He said that he was a drug user, using about £30 of heroin every day, and had last used the day before coming into prison. He acknowledged that he needed help with his addiction. The man said that, before coming into prison, he had been prescribed medication for symptom control relating to his drug use.
24. The man told the healthcare nurse that he had never harmed himself and had no current thoughts of doing so. The Prison Service does not have immediate access to the previous records of returning prisoners, and it takes between 24 and 48 hours to retrieve historical data. Staff therefore have to rely on prisoners being honest about any physical or mental ailments, together with their own visual observations. The healthcare nurse referred the man to the doctor, detoxification and CARATS teams. He was assessed as fit for location on a normal wing and to go to work. The nurse could have provided intermittent relief drugs if he had needed medication to deal with drug withdrawal symptoms, but he did not consider that they were required.
25. Although the man was given prison clothing, because he was a low risk prisoner and not identified as at risk of self harm, he was also allowed to keep one set of his own clothing including a belt and shoes.
26. A short while after completing the reception processes, the reception officer

and two other officers that were in reception, escorted the man and four other prisoners to the induction wing where they were greeted by the night orderly officer. The orderly officer took the man's induction booklet and the CSRA from the reception officers and ensured that the information was correct. As the man was assessed as a low risk prisoner, he was allocated to share cell E2 – 13 with another prisoner. This prisoner told my investigators that he had little conversation with the man that night, but did learn that he was addicted to drugs and was experiencing some withdrawal symptoms.

27. A senior officer arrived on duty in the morning and checked the staffing observation book to see if anything needed to be highlighted which had occurred overnight. No concerns were noted about the man.
28. Shortly after the prisoners had their breakfast, a substance misuse nurse, carried out the man's initial assessment for his drug problem. She told my investigators that she remembered him from at least two previous occasions in the prison, and she described him as a pleasant person. She asked a number of questions, and the man said he had been released from Durham six months previously. On this occasion, he said that he had not been kept in police custody long before reaching the prison. The substance misuse nurse checked to see if he had been given any medication the previous night when he arrived, but he had not.
29. The man told the substance misuse nurse that he had not been prescribed any medication whilst he was outside prison. He said that four months previously he had resumed using £30 worth of intravenous heroin each day, and had last used it on 15 November. He said that he had also been using non prescribed benzodiazepines and amphetamines intravenously. The substance misuse nurse carried out a routine urine sample, and the man tested positive for opiates, benzodiazepines, amphetamines, cannabis and subutex. When asked about the subutex, the man said it was not a drug he regularly used and that he had only taken some the previous day.
30. The substance misuse nurse used a scoring tool to check for any signs of drug withdrawal symptoms. The results only showed mild symptoms. The man told the nurse that he had never overdosed on drugs and did not drink alcohol. She also checked for injecting sites on his arms. Although none was visible, he said he had injected recently. The substance misuse nurse asked the man about any risk of hepatitis B. As he said that he had never been tested, she referred him to healthcare.
31. The substance misuse nurse identified that the man had no physical or mental health problems. His blood pressure and pulse were good, and he said that he had no history or thought of self harm. In conclusion, she described the man's mood as normal and diagnosed opiate dependency. She referred him to the prison's detoxification programme.
32. After the assessment by the substance misuse nurse, the man was interviewed by the substance misuse doctor and nurse. The doctor prescribed lofexidine and zopiclone as part of his detoxification programme, which would

last for five days. The prescription chart would be kept on the man's wing and updated each time he was given lofexidine, which was not to be kept in his possession. However, he was given a supply of zopiclone, to be taken as instructed by healthcare staff.

33. Later that day, the man was interviewed by the probation officer employed by County Durham Probation Area, who works in the prison. She interviews newly sentenced prisoners and those who have been recalled for breaching their licence. The interview lasted about 15 minutes, and the probation officer explained her role and completed an immediate needs assessment form. She asked about the man's housing and family issues, as well as any concerns of self harm. The man raised no concerns. He said that he had previously been in prison and was familiar with its regime. He said he lived in a caravan which he owned. (The probation officer told my investigators this was not usual accommodation for the prisoners she came into contact with.) The man was adamant that he did not need any money to pay the rent.
34. The man's induction continued throughout the day, and he met various prison staff including the CARATS, the chaplaincy, and those offering advice on benefits.
35. During the man's five day detoxification programme, he came into contact with the wing nurses several times every day when he collected his medication. No concerns were noted. He was assigned a detoxification officer, who was expected to ensure that his programme went according to plan. The detoxification officer met the man on Saturday when he checked that his blood pressure was fine and recorded that there were no problems with the lofexidine. There were no further entries to show that he had any problems or requested any assistance with his detoxification programme.
36. The following Tuesday, an officer from the offender management unit interviewed the man. The unit's function is to meet prisoners on around their third day of custody as part of a sentence planning meeting. The officer said she had vague memories of the man from previous periods in custody, and that he once had long hair which he had now cut off. She explained her role and conducted an assessment and sentence plan for him. She told my investigators that the man responded well and participated in general conversation. She recalled him mentioning that he lived in a caravan which he shared with a friend.
37. The offender management officer said that she was not concerned about the man. He interacted well in their discussions about his physical and mental health, and answered all other general questions about his employment, education, debts and allowances. He said that he had one child, and his family were aware that he was in prison and would keep in touch via letters. He told the officer that his sentence was drug related, and he expected to suffer from withdrawal effects during his stay. She was aware that he was on a detoxification programme, and thought that he seemed fine and did not appear depressed in any way.

38. The evening of the following Tuesday was the last day of the man's detoxification programme. As there are no entries to indicate otherwise, and the man's prescription chart was not available, I assume that he completed the detoxification programme successfully. The substance misuse nurse said the man did not report any difficulties about the programme, and by the end she expected him to have passed the worst of the drug withdrawal symptoms. She said that his mind would have been clearer as it would not have been affected by any drugs.
39. The reception officer told my investigators that, although she worked on E wing, she had little contact with the man. She recalled seeing him getting his hair cut, but he did not otherwise come to her attention. She said he was generally polite to staff and seemed to keep himself to himself.
40. After six days on E wing, the man had successfully completed his induction and was ready to move to a residential wing. The senior officer on the wing, told my investigators that during that period he did not come into contact with the man nor did any of his staff raise any concerns about him.
41. E wing officer J came on duty at 7.30am and, after dealing with the breakfast routine, was detailed to be the movements officer for the day. This meant checking to see which prisoners had completed their induction and arranging their transfers. He listed the prisoners who had completed their induction, and compared this with a list of available space on the residential wings. The man was identified as one of the prisoners to be transferred. Officer J spoke individually to each prisoner, telling them that they were to be moved to the wings and, where possible, giving them a chance to express a preference as to where they wanted to be located.
42. Officer J told the man that there were spaces on B wing. He expressed no objections or concerns about being transferred there. The man knew that he would be moved off the induction wing once he had completed his induction and Officer J said that he seemed happy about it. He told the man to pack his personal belongings, and said that he would return to collect him from his cell later that morning.
43. At approximately 10.15am, Officer J returned to the man's cell to escort him to B wing. Two more prisoners were also collected, and Officer J escorted them to D wing first. At around 10.20am, the man and Officer J met one of the SO's as he was leaving B wing. The SO greeted Officer J and the man, and both men acknowledged him.
44. The man was asked to stand near the office until Officer J could check that the wing staff were ready to take him and his paperwork, including his history sheet and CSRA, and to ask whether he had any problems. Officer J had no concerns about the man to pass to the B wing staff.
45. Staff in the office were expecting the man, and said he would be placed on the fourth landing. Officer J knew that the landing officer was on the fourth landing and shouted that he had a prisoner for him for that landing. The landing officer

responded and asked Officer J to send the man up. Before directing the man to the stairs to the upper landings, Officer J checked that the man was okay. He responded positively and thanked the officer. Officer J returned to the office and deposited the paperwork. He told the staff there that he was leaving the wing and that the man had been located by the first landing officer.

46. The man took his belongings up to the fourth floor landing where the landing officer and a second landing officer were situated. The officers recognised him and simultaneously said that he was a familiar face but that he had shaved his hair off. The man acknowledged this and greeted the first landing officer by name. The landing officer described the man's demeanour as no different to how he had remembered him from his previous period in custody. A second landing officer recalled the man as a quiet man who caused no trouble and tended to stick with prisoners from his home area. The first landing officer told my investigators that, the previous time the man had been in Durham, he had been located two cells away from the cell he was allocated in now.
47. When the man arrived on the wing, the staff were in the midst of taking prisoners out for exercise and conducting some cell clearances. He was asked if he wanted to go out on exercise but declined. The first landing officer told him to wait on the landing whilst he completed his tasks and collected his cell card from the office.
48. The two landing officers escorted the man to cell B 4-28 shortly afterwards. It is a double cell and at the time the other occupant (a prisoner that was to become the man's cellmate) was out on exercise. Before locking the cell door, the first landing officer asked the man if he was okay which he confirmed. The officer told my investigators there was no indication that the man was unhappy when he went into his cell.
49. Around an hour later, there was a shout from staff to announce the end of the exercise period and prisoners were escorted back to the landings. The two landing officers had been working in the office. They made their way to the fourth landing to wait for the prisoners to arrive and to start to open the cell doors. Without looking through the observation panel, the second landing officer opened the door of B 4-28 to let in the prisoner, who was to be the man's cellmate.
50. On going into the cell, the cellmate saw the man hanging from the top bunk. The second landing officer immediately entered the cell. The man was hanging from the top bunk with a brown belt around his neck. His face was facing downwards. The second landing officer shouted to alert the first landing officer, who was outside the cell door, and he too entered the cell followed by a third landing officer. The first two landing officers rolled the man round. The first landing officer supported the man, whilst the second untied the belt, undid the buckle and removed it from around the man's neck. The officers laid the man on the floor. From his appearance, they believed that he was already dead. He had urinated, was pale in colour and had no pulse.
51. The first landing officer attempted to take his two-way valve out of the

emergency medical pack on his belt, but the third landing officer was able to get his quicker and passed it to him. The officers commenced cardio pulmonary resuscitation (CPR). The second landing officer tipped the man's head back to get a clear airway and held his nose whilst the third landing officer commenced mouth to mouth resuscitation. Both officers said that, although they had not had any first aid training for more than five years, they felt confident about carrying out CPR. The duty governor had arrived at the cell by this stage.

52. The SO on B wing told my investigating officers that he returned to B wing around 11.20am when prisoners were returning from exercise. He had heard the third landing officer's shout and asked another member of staff to raise the alarm whilst he went to the cell. He arrived within a minute and, as he entered the cell, saw the first two landing officers removing the belt from around the man's neck. The third landing officer was assisting them lay the man on the floor. The SO used his radio and requested Hotel 1, the on duty healthcare nurse, to come to cell B4-28.
53. At around 11.10am, the nurse that was on duty had made her way to the D wing clinic to start methadone treatments. Shortly afterwards, the general alarm bell went off to alert staff that something had occurred. The alarm can be heard all over the building, and is accompanied by green lights flashing on the walls.
54. The nurse immediately made her way to B wing. When she arrived, she saw a lot of activity as prisoners were returning from exercise. She was directed to the fourth landing and quickly ran up the stairs. Whilst doing so, she received a radio call for Hotel 1 to attend the cell. As she was practically at the man's cell, she asked one of the officers present to reply that she was already in attendance. It took the nurse about a minute to reach the cell after hearing the alarm. Until she got there, she was unaware of what had happened and the treatment which would be necessary. A second nurse that was on duty arrived at the same time as the first nurse.
55. The first nurse went into the cell and observed two officers performing CPR. The duty governor asked if there was anything she needed and she asked for the emergency bag and defibrillator. An officer ran down to the B wing clinic to collect the emergency bag, and the nurse moved a table to make space for the bag which was quite bulky. The emergency bag arrived, as did a third and fourth nurse.
56. The third nurse told my investigating officers that she worked as a primary care nurse on E wing, and had not previously come into contact with the man. Her duty began at 7.30am and she carried out her medication rounds with the fourth nurse. During the morning, an officer came out of the office and said that there was a general alarm bell on B wing. Both nurses responded and were guided to the fourth landing on B wing, arriving in less than three minutes. The third nurse said that it was a chaotic scene with a lot of officers present. The nurses saw two officers performing CPR on the man, with the first nurse supervising. The first nurse instructed the third nurse to retrieve the

defibrillator machine from D wing (B wing did not have a defibrillator of its own). The first nurse said that the third nurse quickly returned with the defibrillator.

57. The two officers left the cell and the SO carried out the log keeper role outside the cell. An ambulance was called 11.26am. The second nurse left the cell to get an oxygen bottle from B wing clinic. When she returned, the third nurse had taken over chest compressions, and the fourth nurse was maintaining the man's airway. CPR was correctly delivered at a ratio of 30 breaths to two compressions for a cycle of approximately three minutes. The defibrillator was applied by the first nurse to the man's body to advise her whether to administer a shock. The defibrillator advised not to shock, and so resuscitation continued for approximately 20 minutes. The third and first nurses alternated between cardiac compressions and operating the defibrillator.
58. The prison doctor arrived approximately 20 minutes after the nurses commenced CPR. The man was again assessed and the defibrillator advised to continue with CPR. This continued for approximately five further minutes, when it again advised no shock. The man was reassessed by the doctor. At approximately 11.45am, he instructed staff to cease CPR and pronounced the man's death.

After the man's death

59. The prison has set procedures for responding to a death in custody, and these were instigated by staff. The cell area was isolated and the police informed. The police arrived later that afternoon, together with a member of the Independent Monitoring Board and a chaplain.
60. All prisoners in the wing who were on an open ACCT were interviewed during the day. The man's cell mate was also spoken to and offered support. He was subsequently moved to a new cell with two other prisoners.
61. The staff care team was available to support staff immediately after the man's death. They also attended a hot debrief at 2.30pm held by the Governor where they discussed the morning's events and were commended for their efforts to try to revive the man. Statements were also taken from staff involved. All the staff interviewed were satisfied that the level of support offered at the time was adequate for their needs. At interview for this investigation, one member of staff said that they were still in need of further support. My investigators informed the Safer Custody Manager and I am pleased that counselling services were instigated immediately.
62. The man's body was removed from the prison at 4.25pm.
63. The two prison family liaison officers were briefed immediately by the duty governor and asked to trace the man's family. His records showed that his next of kin was his sister, and her address was a caravan site approximately two miles from the prison. The officers went to the caravan site, where they found a friend of the man lived there. The man's friend told them that he did

not know how to contact any of the man's family.

64. Prison staff contacted the police who found the address of the man's parents. It was decided that the police officers would visit and hope to find his sister or parents. They arrived at around 5.30pm and told the man's parents of his death. The family was given contact details for the prison and the family liaison officers. The prison later provided financial support for the funeral costs and arrangements were made to return his personal belongings.
65. The following day, the safer custody officer briefed the Samaritans and Listeners and a Governor's notice was issued to staff and prisoners to inform them of the man's death.
66. The post mortem report confirmed that the man's death was caused by hanging. The toxicology results showed that there were only faint traces of diazepam in his system.

ISSUES CONSIDERED IN THE INVESTIGATION

Clinical Care

67. No particular issues have been raised in the clinical review about the healthcare provided to the man at Durham. He was immediately placed on a detoxification programme, which was apparently completed successfully. However, his prescription sheet was missing, and there is no evidence to confirm what was administered each day, and if the detoxification programme was completed. It is essential that medical records are maintained appropriately to ensure a contemporaneous record of care and treatment.

The Healthcare Manager must remind staff of the importance of maintaining confidential medical records in accordance with the standards identified by professional bodies.

Access to the emergency medical equipment

68. When the man was discovered, the first nurse in attendance at the cell requested the emergency bag and the defibrillator. The emergency bag was brought by an officer, and another nurse subsequently retrieved the defibrillator from another wing. The short delay was because at the time a defibrillator was not kept on B wing, something that the officer who went to retrieve it would not have known.
69. Despite the short delay, the clinical reviewer confirms that it did not adversely affect the outcome of the attempts to resuscitate the man. I am pleased that, since the man's death, the prison has now provided a defibrillator on every wing.

First aid

70. The first officers to arrive at the man's cell were confident about administering first aid although they had not been trained for several years. I have previously recommended that first aid training is provided for all staff in contact with prisoners. In this case the officers were competent, even though they had no knowledge of current advice about the proportion of breaths to compressions in CPR. I suggest again that basic life support or first aid training should be reviewed for frontline staff to ensure that they are fully up to date with procedures.

The Governor should review the need for first aid or basic life support training for staff on frontline duties.

74. In the time since a previous investigation at Durham, I have been pleased to learn that the Governor has implemented my recommendation and issued all officers with a personal emergency first aid pouch, containing resuscitation equipment. The pouch is worn on the officer's belt and contains a non-return valve, rubber gloves and disposal bag. Both officers who were first to arrive at the man's cell were carrying their pouches and used the contents until the

emergency bag was obtained.

75. The carrying by front line staff of personal emergency first aid pouches which contains resuscitation aids is good practice. I urge the Prison Service to consider extending this across the prison estate, beginning with all local prisons.

The Prison Service should consider the issue of personal emergency first aid pouches as standard issue to all front line staff.

CONCLUSIONS

76. The man was an experienced prisoner, having served a number of custodial sentences. On this occasion, it appears he successfully completed a drugs detoxification programme and remained drug free during the six days he was at HMP Durham. He had a number of apparently positive, but low key, interactions with staff during what seems to have been an uneventful week. He expressed no signs of concern or distress.
77. Given that he had received a two months sentence, the man would have remained in custody for just a few weeks more before being released.
78. The man had harmed himself during a previous sentence, but this was not known to the staff who reviewed him when he was received into custody. The unavailability of past custody records is a weakness in the systems for ensuring the care of prisoners. However, even if staff had known of the man's past self-harm, its relatively minor nature and the absence of any signs of distress on this occasion mean it is unlikely that any different actions would have been taken.

RECOMMENDATIONS

1. The Healthcare Manager must remind staff of the importance of maintaining confidential medical records in accordance with the standards identified by professional bodies.
2. The Governor should review the need for first aid or basic life support training for staff on frontline duties.
3. The Prison Service should consider the issue of personal emergency first aid pouches as standard issue to all front line staff.