

**Investigation into the circumstances surrounding
the death of a man at HMP Durham
in March 2009**

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

July 2010

This is the report of an investigation into the death of a man at HMP Durham in March 2009, eight days after he came into custody. He was found hanging by his cellmate at about 6.30pm and, despite resuscitation attempts, was pronounced dead 25 minutes later. The cause of death was determined by post mortem as hanging.

The senior family liaison Officer (FLO) met with the man's family at the beginning of the investigation. I would like to add my personal condolences to those already expressed on my behalf to the family and friends in Sunderland by the FLO. I must apologise for the delay in producing this draft report.

My investigator was appointed to investigate the circumstances of the man's death, assisted by a colleague. We would like to thank the Governor and his Acting Governor for the resources they gave the investigation. My particular thanks go to the liaison officer who assisted the investigation team throughout the process.

We are grateful to the local Primary Care Trust (PCT) for the appointment of an independent clinical reviewer, a GP from Middlesbrough PCT. He examined the clinical care that the man received during his short time in custody. His review is the first annex to the investigation report.

The man was undergoing alcohol detoxification for the first time during his brief time at the prison. He was referred for further support and a mental health assessment but neither had taken place before he died. He was found by his cellmate after association when he stayed alone in his cell.

My report considers the treatment that the man received for his alcohol detoxification. While I believe it was clinically appropriate, there were few other measures available to support him through this vulnerable time. I make one national recommendation to National Offender Management Service (NOMS) about resources for prisoners going through alcohol withdrawal. I also consider whether the emergency response was reasonable and make one recommendation about staff care. I examine the adequacy of the health screening processes for new prisoners and make two related local recommendations, and one national recommendation to the Department of Health. Finally, in response to the man's family's concerns, I make one recommendation about visits.

The man was the first of four self inflicted deaths in just over two months at Durham. The four deaths have been investigated separately, and although there are no obvious similarities between his death and the three others, the investigation team has liaised with other investigators to share the lessons learnt.

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

Jane Webb
Acting Prisons and Probation Ombudsman

July 2010

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SUMMARY

The man was remanded into the custody of HMP Durham on 4 March 2009, charged with threatening to kill a family member. At 48 years old, he had been in prison before, but not for a nearly 20 years.

During his initial health screen, the man told staff that he was dependent on alcohol and misused drugs. He said that he was prescribed medication for depression in the community. A routine urine sample indicated that he had heroin, benzodiazepines (anti-anxiety medication), and cannabis in his system. (In fact, the test determined that the presence of opiates in the blood and the positive heroin result were caused by the prescription drugs and he had not used heroin.) Following the screen, he was referred to the doctor and for detoxification. The doctor assessed him in reception, and referred him to the substance misuse nurse for clinical detoxification for alcohol. The doctor made a routine mental health referral so that his depression could be assessed.

The doctor in reception requested the man's medical records from his community practice. Although the request was made, it was not followed up and the medical records were not received at Durham until after his death. The routine secondary health check he was due in the days after his arrival at Durham did not take place due to an administrative error.

The man spent a week on the first night centre. He collected his medication from the nurse stationed at a treatment hatch on the wing three times a day. The nurses who administered the treatment remembered how polite and friendly he was during their brief contact with him. They were not required to physically examine him, but noticed no deterioration in his condition during these exchanges.

On 11 March, the man was transferred to the largest residential wing in the prison. He was located in a shared cell and spent the following day playing cards and talking with his cellmate. The cellmate left the cell for a period of association at about 6.00pm. (Association is a daily opportunity for prisoners to mix on the wing out of their cells.) He decided not to come out of his cell and was locked in for the duration of the association period, a matter of procedure in Durham. The cell door was unlocked again at 6.30pm when the cellmate returned.

As the officer who opened the door stepped away from the cell, the man's cellmate noticed him hanging from the window frame. He shouted at officers to assist, and the nearby officer ran into the cell. The officer shouted for help from his colleagues and was joined by another officer. The general alarm was sounded, and a radio call was made requesting emergency medical assistance. Officers found he was not breathing and started resuscitation attempts. The emergency response nurses arrived, followed by a colleague with necessary medical equipment, and they assisted with resuscitation. A defibrillator was used but it showed no sign of life and the response nurse called for the doctor. (A defibrillator is a device used to measure whether there is any activity in the heart that might be restarted using an electric shock.) The doctor pronounced him dead at 6.55pm.

The man's clinical detoxification was managed appropriately, although I am

concerned about the lack of support for prisoners in any prison withdrawing from alcohol. I examine the accuracy of the first reception healthscreen, especially relating to urine testing for substance misuse. The man's medical records were not received at the prison until after his death, which affected his treatment for depression. I consider the response to the discovery of him hanging and conclude that resuscitation efforts were adequate. I also examine the arrangements for the prison's contact with his family after his death.

THE INVESTIGATION PROCESS

1. My investigator was appointed to lead the investigation into the man's death. She visited the prison on 20 March to open the investigation. She met the Governor of HMP Durham at the time, who is now the temporary Director of Offender Management for the North East.
2. During her visit, my investigator also met the appointed investigation liaison officer who arranged for her to speak to a member of the Prison Officers' Association (POA), the Independent Monitoring Board (IMB), the Health and Safety representative for the prison, a representative of the Staff Care and Welfare Service, the family liaison officer for the case and the prison's lead doctor. The liaison officer provided my investigator with a copy of the man's records. Notices were distributed around the prison, inviting prisoners and staff to contact the investigator with any information relevant to the investigation. There was no response to these notices.
3. I am grateful to North East Offender Health and the local Primary Care Trust (PCT) for the appointment of a clinical reviewer to conduct an independent clinical review into the medical care that the man received during his short time at Durham. My investigator, the clinical reviewer, prison doctor and a Registered Mental Health Nurse (RMN) attended a clinical review meeting at the prison on 7 April 2009.
4. I am grateful to Offender Health's substance misuse lead for his advice about urine testing during the first reception healthscreen.
5. My investigator wrote to the man's cellmate to ask him whether he was prepared to be interviewed for the purpose of this investigation. There was no response to the letter. The investigator relied on the information that he gave in his statement to the police, and I am grateful for their co-operation.
6. The senior family liaison officer, another family liaison officer and my investigator met the man's family on 30 April. I would like to thank his family for their contribution at such a difficult time. The family were concerned about the way they were told the news of his death. They wanted to know whether it was normal procedure to lock a prisoner's cell during the association period. The man's sister also told the investigation team about her attempt to visit him and that she raised concerns about his depression with officers. I trust this report goes some way to answering the concerns they raised during that meeting and subsequent contacts with the senior family liaison officer.
7. The investigator, accompanied by a colleague, interviewed 14 staff in May 2009. Staff who were unavailable on these dates were interviewed by telephone in the following weeks.
8. My investigator wrote to Her Majesty's Coroner for Darlington and South Durham/North Durham Districts to inform him of the nature and scope of my

investigation. I am grateful to him for providing a copy of the post mortem report.

9. Following consultation on the draft report, the family's appointed solicitor made representations on their behalf that required further investigation. In particular, a prisoner made a statement about his contact with the man during his time at Durham and subsequent conversations he had with staff. This resulted in two telephone interviews with these staff members, which can be found as the last two annexes to the investigation report.
10. Following the four deaths in Durham between March and May 2009, NOMS in the North East undertook a thematic review. I am grateful to NOMS for sharing the report with my office and I refer to it later in the report.

HMP DURHAM

11. HMP Durham is a local prison that serves courts in the Durham area. As such, it accommodates up to 981 adult males who are sentenced and on remand. Prisoners that have used drugs or alcohol are prescribed detoxification treatment from the substance misuse team.
12. Her Majesty's Chief Inspector of Prisons carried out a full inspection of Durham in September 2006. The inspection team found that reception and first night arrangements were "very good". They went on to examine the procedures in place to look after prisoners at risk of suicide and self harm and found that they were generally of a "good standard".
13. The Chief Inspector noted that the suicide and self harm policy included good reference to risk to those prisoners going through detoxification. However, she was worried that there was no discrete detoxification unit and that the role of the detoxification officer was not clear. The Chief Inspector was also concerned about the apparent lack of an alcohol strategy at Durham. She wrote that alcohol detoxification was seemingly limited to clinical treatment. Since that inspection, the prison have written and ratified an alcohol strategy which was in place before the man came into custody.
14. The Chief Inspector also recommended that there should be an immediate review by the area manager of practice following death in custody reports. The inspection team found that recommendations made by the Ombudsman had not all been implemented and recommended that they should be so as "a matter of urgency".
15. During her inspection, the Chief Inspector found that the reception area at Durham was poorly designed, but that the prison managed well with the large number of prisoners passing through every day. She also described "first night and induction services as good" although was concerned that not all prisoners were offered a free telephone call. (I am pleased to report that the man received his free telephone call and used the telephone on the night that he arrived at Durham.)
16. The Independent Monitoring Board (IMB) noted "with concern" the high number of prisoners going through reception. In their annual report for 2007-2008, the IMB wrote that such a high number of prisoners risked "increasing the risk to safety and wellbeing of prisoners and staff". They particularly noted occasions when medical assessments could be delayed by the large number of prisoners arriving at the prison at one time. (Again, I am pleased to say that the man experienced no such delay during his time in reception and received two prompt medical screens.)
17. While their report is silent about the effectiveness of prisoner detoxification at Durham, the IMB noted that providing the mental and physical health treatment required by such a large number of prisoners passing through the prison is a "tall order". Following the inspection report, the IMB also noted

that the prison's action plans following deaths in custody were up to date and being complied with.

18. The man's death was the first of four deaths between 12 March and 18 May 2009, just over two months. There is little similarity between his death and the three other deaths, although all four prisoners were affected by drug and alcohol misuse. However, although the three other deaths were apparently self-inflicted, they occurred when prisoners were subject to suicide prevention measures. A thematic review of those deaths on was carried out by NOMS in the North East. As he was not on suicide watch at the time he died, his death was not part of the review. The conclusion of the review was that suicide prevention procedures at Durham did not meet the "rigorous standards" required by the Prison Service. However, the report also concluded that "procedural weaknesses identified in the review did not contribute directly to the prisoners' deaths".

KEY EVENTS

19. After his arrest on 1 March, the man was remanded into the custody of HMP Durham on 4 March 2009, following an appearance at a magistrates' court. His case was referred to crown court due to the seriousness of the alleged offence.
20. When he arrived at Durham, a Healthcare Officer (HCO) interviewed him for the first reception healthscreen. (A first reception healthscreen takes place every time a prisoner arrives at a prison to determine any immediate physical and mental health conditions that require treatment, substance misuse matters that need to be addressed, and any risk that the prisoner may pose of harming himself or attempting suicide.) He told the HCO that he had been in prison before, 20 years previously. He said that he had been assessed by a doctor "in the last few months" for depression and was prescribed Amitriptyline and Codeine Phosphate. (Amitriptyline can be used as an anti-depressant or, in a lower dose, to manage pain.)
21. When asked about his drinking and substance misuse, the man admitted to drinking one litre of vodka daily. He said that he took cannabis and cocaine at weekends. As a matter of routine, a urine sample was taken and tested during the reception process. The following results were marked on the record of his first reception healthscreen:

	Frequency	Amount	Last Used	Withdrawing	Urine Result
Heroin					+ve
Methadone					
Benzodiazepines					+ve
Amphetamines					
Cocaine	Weekends		2/7		+ve
Subutex					
Other	Cannabis				+ve

('+ve' indicated a positive result)

22. The HCO told the investigation team that a member of the healthcare team completing the first reception healthscreen would not ordinarily talk to the prisoner about their urine test results. He said that, despite the man being recorded as testing positive for heroin, the result only indicated that he had taken opiates. The man had already told the HCO that he was prescribed codeine phosphate in the community, which is classified as an opiate and would be recorded as a positive heroin result. (I consider the appropriateness of the form's wording later in the report.)

23. When prompted to write whether the man had received treatment for mental health, the HCO wrote "Amitryptiline?". He explained to the investigation team that he questioned the man's response:

"that's because he couldn't tell me the correct dose he was on so I question marked that, and that's to be checked out later with his GP when we confirmed his medication".

24. As required, the HCO asked the man if he had ever harmed himself. The man explained that he had attempted to overdose 18 months previously but that he had no more thoughts of self-harm. Assessment, Care in Custody and Teamwork (ACCT) is the suicide prevention system used by NOMS to identify and support prisoners who are at risk of suicide or self harm. The HCO did not open an ACCT document following the reception healthscreen.
25. The healthscreen form requires an explanation if a prisoner has a history of self-harm, but no ACCT is opened. Under this section, the HCO has only written "No". During interview for this investigation, he said he would ordinarily have written "no, okay now", and could not remember why he had not written a fuller statement. Although he could not specifically recall the man's healthscreen, he told the investigation team that he finds that prisoners are honest about thoughts of self harm. He takes other things into consideration when making his assessment, for example: "Is he giving you any eye contact, how is he speaking to you? Is it monotone his speech? Is he constantly up and down?"
26. The HCO referred the man for detoxification treatment and to be assessed by a doctor. The HCO did not make a mental health referral, despite the man indicating that he was receiving treatment in the community for depression. During his interview for the investigation, he explained he understood that the man was receiving mental health treatment from his GP in the community, rather than from acute mental health services, for example, a psychiatrist. Therefore, he concluded that the man's mental health needs were not acute and could be effectively dealt with by the prison doctor.
27. The man was assessed by a doctor in reception, following the first reception healthscreen. One of the prison doctors works in a nearby community GP practice, as well as working at the prison for the last five years. Along with two other local GPs, he visits the prison on weekday evenings to assess prisoners who have been referred to the doctor. He read the man's first reception healthscreen and spoke to him about his substance misuse. He told the doctor he drank a bottle of vodka and 12 cans of beer every day and he had used diazepam, cannabis and cocaine since he was a teenager.
28. By the time of the doctor's assessment, the man had not drunk alcohol or taken drugs for two days as he had been in police custody prior to arriving into prison. The doctor noticed that he was "not ill, looks much older than his years, fine tremor of fingers". He told the investigation team that the tremor "was probably not related to drug dependence, but related to a drug,

particularly benzodiazepine withdrawal, alcohol withdrawal". He went on explain that some people going through alcohol withdrawal "look extremely unwell and very irritable and can fit, [the man] did not fit into that group".

29. The doctor agreed with the HCO that the positive heroin result did "not imply he's used heroin at all". It was his experience that prisoners who take heroin would "have no reluctance" to talk about the extent of their problems. He did not ask the man about his positive urine result, but understood it to mean that he had used either codeine or dihydrocodeine (both opiate-based painkillers).
30. The man told the doctor that he had been diagnosed with depression but described his mood as "okay now". He also spoke about his attempt to take an overdose 18 months before. The doctor referred him for a mental health assessment because of his history of self harm, so that the diagnosis of depression could be further explored.
31. The administrative assistant for the mental health team explained to the investigation team that a routine mental health assessment could take between six and eight weeks to complete, depending on the availability of staff. An urgent mental health assessment can take place within 24 hours. When asked why he did not make an urgent referral, the doctor said:

"I didn't feel that it was anything that was desperately urgent. Although I have identified that there is a mental health issue, I didn't feel that there was a particularly urgent mental health issue there ... I didn't feel that he needed to be seen by the mental health people the next day."

The doctor confirmed that he understood that a routine mental health referral would take longer and he was happy for that to be the case.

32. The doctor asked for the man's medical records to be retrieved from his community practice to confirm his diagnosis and medication. (In fact, the medical record showed no recent diagnosis of depression.) The doctor understood that such a request would be processed by administrative staff in the healthcare centre at the prison. When asked why he had put this instruction in capital letters, the doctor told the investigation team:

"I think that was to draw particular attention to it. I think because I felt we needed to know what the history was of the overdose and any other psychological history."

(Despite the doctor's clear, capitalised instruction, the man's medical records were not received at Durham until after his death eight days later.)

33. Telephone records show that the man spoke to a family member later that afternoon. (Every prisoner must be given the opportunity to use the telephone on their first night in custody.) The transcript of this conversation shows that he asked his relative to find the telephone number of his alleged victim, so that he could speak with them and get the charges dropped. Upon

hearing this, an officer, who was monitoring telephone calls for security purposes, raised a Security Information Report (SIR). Details of the telephone call were passed to the prison's police liaison officer and it was decided that no further action was required. During a further short telephone conversation that afternoon, the alleged victim refused to visit the man.

34. The next day, 5 March, the administrative assistant requested the man's medical records from the surgery in the community. The request was sent by fax, requesting an immediate faxed response. The Healthcare Administrative Manager for Durham explained that records that are not received within two clear working days of the request are usually followed up by the administrative assistant, in this case the administrative assistant. Unfortunately, 5 March was a Thursday and the administrative assistant was on leave for the following week. During this time, the prison's computer system failed which added to the confusion and the man's records were not requested again.
35. Later that day, a Registered Mental Nurse (RMN) met with the man to discuss his substance misuse needs. The RMN is the substance misuse nurse appointed for Durham. The nurse discussed alcoholism with him, and the man repeated that he had started drinking from a young age. He said that he had not previously tried to stop drinking. During his assessment, he said that he was experiencing stomach cramps and mild tremors, which are signs of withdrawal. The RMN described the man as "bright, pleasant, chatty and jovial in mood", during their conversation. The nurse prescribed a clinical detoxification, starting on 40 milligrams (mg) of Chlordiazepoxide and decreasing over the ten day clinical detoxification.
36. Despite recording that the man had intentionally overdosed twice (in 2007 and 2008), the RMN also wrote in his records: "no past history of self harm and no suicidal ideation expressed at any time of assessment". He told my investigation team that he is confident about ACCT procedures and would have opened an ACCT document if he had any concerns, but there was "nothing whatsoever".
37. The RMN did not record any information about the man's urine testing positive for heroin. He told the investigation team that he did not ask him about the result, because he understood that it indicated simply that the man had codeine in his system, not necessarily heroin. He said that prisoners who are withdrawing from heroin need a high level of support and are not reluctant to tell staff about their use of the drug and consequent detoxification needs. Despite not asking directly, the RMN was satisfied that the man was not a heroin user, judging by the way he presented himself.
38. That afternoon, a CARATS worker completed a CARATS assessment with the man. (CARATS stands for Counselling, Assessment, Referral, Advice and Throughcare Services and is the service used nationally to support prisoners with substance misuse needs.) Every prisoner at Durham meets a member of the CARATS team as part of their induction process to establish whether they have any substance misuse needs. She remembered that he

was positive about the detoxification programme. He said it would help him to stop drinking for the sake of his children and marriage. The CARATS worker described his alcohol use as “heavy”, but was impressed at his honesty. She assesses the risk of self harm in each of the prisoners she meets. He told her about his attempt at overdose 18 months before. He said that he was stopped in his attempt by a friend who reminded him that his children needed him. He told her that he had no thoughts of self harm and she recalled to my investigation team that “he seemed perfectly honest, I had no reason to doubt him”. The CARATS worker devised a care plan, including group sessions and one to one work. Sadly the man died before he had the opportunity to access any of these services.

39. Two friends visited the man on the morning of 6 March. He spent the next few days on the first night centre, completing the induction programme and learning about the rules and regime of the prison. He collected his detoxification medication three times a day from the treatment hatch on the wing. Nurses described the process to the investigation team. The medication is dispensed from the pharmacy and taken to the wing. Each prisoner waits in line for his medication in the morning, at lunchtime and in the evening. When the prisoner reaches the front of the queue, he steps forward out of the line towards the nurse. Although there is no physical barrier, the nurses told the investigation team that the exchange between nurse and prisoner is private due to the distance between the queue and the treatment hatch. Nurses do not carry out a physical examination of the prisoner when they dispense medication, but they look for signs of deterioration in someone’s condition. The nurses could not remember noticing anything concerning about the man’s presentation. They recalled his politeness and humour in the brief exchanges they had three times a day.
40. On Sunday 8 March, the man’s sister tried to visit him but was refused entry by staff in the visits area. She told the senior family liaison officer from this office that she arrived at 9.00am and waited for half an hour, before being told he was not allowed another visit. She recalled speaking to a male and a female officer in her efforts to visit her brother. The investigation team spoke with two officers who worked in the visits area that day. Neither of the officers recalled speaking to the man’s sister. The man’s sister told the senior family liaison officer that she mentioned her brother’s depression to the officers and asked them to start suicide prevention measures. Neither officer recalled that conversation. Both told the investigation team that they would have contacted the wing to pass on any such concerns, and open an ACCT document if appropriate.
41. The man was due to have a secondary health check on 10 March. (This is a physical health check, similar to that received in the community when a patient joins a community practice.) Due to staff shortages the Primary Care team leader was tasked with completing the secondary health checks that day. It would not normally be her role. She visited the prisoners’ cells and took basic observations, for example the prisoner’s blood pressure. However, when she reached the man’s cell, he had been taken to court and

she could not complete the health check. She indicated that he was at court, but also noted in error that she had assessed him. (If a prisoner is unavailable for the secondary health check, they would normally be added to the list for the following day.) Due to her error, he was not added to the list because the form showed that he had already been assessed.

42. The medication required for the man's clinical detoxification was taken to court by staff, so that he could continue his treatment. His family told the investigator that he had thought an appearance from his alleged victim would have led to his release that day. The alleged victim did not appear in court. He was remanded back to custody and his case was committed to crown court.
43. After the draft report was issued, the family provided a statement from another prisoner who was at Durham at the same time as the man, who was also a family friend. (My investigator wrote to the prisoner during the course of the investigation but did not receive a response.) In his statement, the prisoner said he was at the magistrates' court on the same day as the man. He was worried that the man was upset about his personal circumstances and, although the man did not mention suicide or self harm, the prisoner described him as "clearly in a distressed state". When they got back to the prison, the man and this prisoner ate together in the reception area before going back to their different wings. The prisoner was located on D wing and the man returned to the first night centre.
44. In his statement, the prisoner wrote that he spoke to an officer about whether it would be possible to arrange for the man to transfer onto D wing, "where he could keep an eye on him". The prisoner told the investigator that he said to the officer that he did not want the man "to become another statistic", by which he meant that he was at risk of suicide. The prisoner said that he also spoke to a SO on the same day and again asked whether the man could transfer to D wing. The prisoner said he used the same expression to describe his concern that the man was at risk of suicide. When my investigator spoke to them, neither the officer nor the SO remembered having such a conversation with the prisoner in question.
45. The following evening, the man was transferred from the first night centre to A wing, the largest wing in the prison. He was located in a shared cell on the second level.

Thursday 12 March

46. In his statement to the police after the man's death, his cellmate said they spent the following day together in their cell watching television and playing cards. The man spoke openly about how his "head was in bits" due to his personal situation. They ate their lunch together in their cell and ordered their meals for the next day. His cellmate noticed that the man wrote a letter that afternoon. He told the police that there was nothing in his behaviour or their discussions that made him think that he would kill himself.

47. The man collected his medication, 10mg chlordiazepoxide, at 4.00pm that afternoon. A nurse was at the treatment hatch. During interview with the investigation team, she remembered having seen him that day. She explained that when administering treatment, she would assess a prisoner's physical appearance and their presentation to ensure that they could take their medication safely. She did not remember anything that caused her concern about him on that occasion.
48. Prisoners are allowed out of their cells for an hour long period of association at about 6.00pm every other evening. During this time, they can shower, use the telephones and mix with other prisoners on the wing. Prisoners who do not associate are locked in their cells to prevent other prisoners from going into their cells and minimise opportunities for bullying. The man's cellmate left the cell for association, but he preferred to stay in his cell. An officer unlocked their cell and looked in when the man's cellmate left for association. He said he noticed "nothing untoward". In his section of the wing, the cell doors automatically locked when they were closed. The man was locked alone in his cell, with the observation panel on the door shut.
49. The officer was standing outside the showers with another officer during the association period. He was observing the shower area and taking prisoners back to their cells on the second landing. He was also observing the telephones located on either side of the door to the man's cell. During interview for this investigation, the first officer told the investigation team that he did not hear anything "untoward" and prisoners did not alert him to anything happening in the man's cell during that time.
50. The man's cellmate approached the first officer and asked to be taken back to his cell at about 6.30pm. The officer had to continue to monitor the showers with the second officer as well as escort the man's cellmate. The officer unlocked the cell door and looked behind him to the shower area. The cellmate went into the cell. The officer heard a scream. He saw that the man was hanging from the window with a torn bedsheet used as a ligature around his neck. The cellmate was moved to another cell.
51. The sequence of events over the next five minutes is confusing. The officer shouted the word "staff" for assistance and the second officer ran to the cell. The first officer thought that the second officer pressed the general alarm as he ran past it on the wing, but the second officer assured the investigation team that he did not do so. He said that he carried a radio, but did not use it. The first officer thought that neither officer had a radio that day, because their duties did not demand it. Instead, they depended on the general alarm to get assistance from staff. (A general alarm is used to alert staff to incidents on the wing where staff assistance is required.)
52. The first officer went into the cell and supported the man's weight. The second officer followed him into the cell. Using the anti-ligature knife that he carried on his belt, the second officer cut the bed sheet and helped the other officer to lower the man to the ground. Once they had laid him on the ground, the first officer went to the door to see if healthcare staff were on

their way. The second officer checked whether the man was breathing and looked for a pulse on his neck. He found no signs of life, and started mouth to mouth resuscitation.

53. A third officer was nearby and heard the alarm. During interview with the investigation team, he said it took around 15 seconds to get to the cell. On arrival, he called a "Code Black" over his radio. (A Code Black is used when a prisoner is unconscious and alerts healthcare staff that they are needed.) At the same time, two officers from the Safer Custody team arrived. The fourth officer also made a Code Black radio call. The fifth officer took over mouth to mouth resuscitation from the second officer and the fourth officer started chest compressions.
54. A nurse was the emergency medical response nurse that day (known as 'Hotel One'). She was assisting the doctor in the reception area of the prison, next door to A wing, where the man was located. She heard the general alarm. During interview for this investigation, she told my investigator that a general alarm usually means that a fight is taking place. Medical assistance is often required after such an incident, so she suggested to the doctor that they wait where they were, in case they were needed.
55. Shortly after hearing the general alarm, Hotel One remembered hearing the location of the emergency over the radio as being on the second landing of A wing. She said she still thought it was a fight because the location meant that the incident was near the central staircase, which is a busy area where there can be a lot of fights. A second radio message requested Hotel One. She told my investigation team that she did not hear a Code Black message. She said if she had heard a Code Black, she would have known that a prisoner was hanging. Instead, she made her way to the emergency, without knowing. She reached the man's cell around three minutes after the general alarm was raised. She requested emergency equipment and for an ambulance to be called.
56. A second nurse heard the Code Black call and knew that medical equipment needed to be taken to the cell. She was designated to take equipment to any emergency that day. She took the emergency grab bag and the defibrillator. By the time she reached the man's cell, Hotel One had checked his breathing and pulse and assisted with chest compressions. The nurse arrived and set up the defibrillator. The advice from the defibrillator was not to administer an electric shock to him and so resuscitation attempts were continued.
57. An (Acting) Senior Officer (A)SO was the manager of A wing that day. She heard the general alarm while she was on the fifth floor of the wing. By the time she arrived at the cell, Hotel One and the nurse had taken control of the situation. During interview for this investigation, the (A)SO estimated that it took her five minutes to get from the fifth landing to the second landing. She said that it took a long time because she had to make sure that prisoners were returned to their cells. She explained to the investigation team that her

priority was to ensure that no prisoners could look in the man's cell. The A(SO) also spoke to the staff involved to support them and encouraged those who no longer had a role in the emergency response to move to a quiet area.

58. The Hotel One response nurse and another nurse continued their resuscitation attempts. The response nurse asked that the doctor be called from E wing to assist. The doctor reached the cell before the ambulance had arrived. He pronounced the man dead at 6.55pm.
59. The man's family told the senior family liaison officer that a prisoner was on the telephone as the events unfolded and knew that the man had been found hanging. This prisoner told the person he was speaking to, and a rumour started in the man's local area about his death. The (A)SO agreed that this was regrettable but in practice difficult to prevent. She told the investigation team that there were no telephones in the area. The investigator visited the man's cell and saw the telephones located on either side of the door.

Prisoner Support

60. After the man's death, the (A)SO broke the news to the cellmate about what had happened. He was given a drink and some tobacco and they had what she described as "a lengthy chat". She offered the prisoner access to the Samaritans and a Listener. (Listeners are prisoners trained by Samaritans to provide confidential emotional support to fellow prisoners in distress.) Also, he was moved to a cell with a friend for extra support. A Principal Officer (PO) from the Staff Care and Welfare Service also visited the man's cellmate to check on his wellbeing.
61. The (A)SO spoke to another prisoner on the wing, who had been identified as at risk of self harm, in line with prison procedure.
62. All the prisoners were offered support from the Listeners and the chaplaincy.

Family Contact

63. Durham's Family Liaison Officer (FLO), a Senior Officer (SO), was contacted at 8.00pm on 12 March and told about the man's death. The police advised the FLO to have an escort when breaking the news to the family. Arrangements were made for the FLO to meet the police at a police station local to the man's family in order to visit the man's wife and notify her of his death. The FLO's records show that she followed the police to the home address at 11.30pm. The man's daughter was there and told the police and the FLO that her mother was not at home. The daughter contacted her mother on her mobile and told her that staff from Durham prison were there. After half an hour, just after midnight, the police were told that the man's wife would not be available that evening. They took the decision to return the following day.

64. The FLO contacted the Probation Service the following morning, 13 March, to find out further information about the man's next of kin. The police were contacted again and advised that they would notify the man's wife in person. The FLO briefed the police about the circumstances of the man's death and asked that his wife be given her contact details to speak to her after the police visit. At 11.25am, following the police visit, the man's wife telephoned the FLO, who told her in more detail about what had happened to her husband. She made no further contact with the prison until she collected his personal belongings some weeks later.
65. One day later, on 14 March, the man's mother, sister and a friend went to the prison and met the Governor. The Governor met them at the gate of the prison and brought them in to meet the FLO. They told the FLO that they were unhappy that they did not hear about the man's death until the day afterwards. The FLO explained that it is prison procedure to notify the listed next of kin before notifying anyone else of a prisoner's death. The senior officer had been unable to speak to the man's wife on the evening of his death, so it was not possible to speak to other members of his family until the following morning. The FLO made arrangements to visit the man's mother and sister at their home.
66. In line with normal procedure, the prison FLO checked with the prison's police liaison officer about any security issues regarding visiting the family in their home. She was advised that officers should not visit the address and should arrange for the visit to be held elsewhere. On 17 March, the FLO telephoned the man's mother and spoke to his sister. The FLO asked whether the family would consider meeting at the prison, but they refused this offer. The family preferred to meet at their home address, but following police advice, the FLO proposed an alternative venue. The family also asked that a representative from the prison attend the funeral. Again, the police advised the prison not to attend and said that the prison's attendance would require extra police resources. The FLO explained this to the man's sister. Eventually, the FLO agreed with the man's sister that there would not be a representative from the prison at the funeral but that she would contact her afterwards to arrange to meet at a local hotel. This meeting went ahead on 27 March, attended by the man's mother, brother and two sisters. The FLO recorded in her log that the meeting served to "give the man's family the truth and reassure them" and she offered to answer any queries should they want to contact her in the meantime.
67. According to the prison's family liaison log, the man's wife attended the prison and collected his property on 8 May. She thanked the family liaison officer but explained that she wanted no further contact.
68. On 15 June, the man's sister contacted the prison and spoke to the FLO at length. She wanted an update on the situation, including the progress of the Ombudsman's investigation. The FLO told her that the Ombudsman's investigation was being conducted independently from the prison and she encouraged the man's sister to contact our office directly. The man's sister had expected the prison to maintain contact. The FLO explained that she

would not normally be in touch with the family, but would answer any queries should they want to know anything about the prison or the man's time here. Another sister joined the conversation and said that the family were unhappy that contact had not been maintained by the prison. According to her log, the FLO said she would be happy to arrange another meeting if the family would find it helpful, but the conversation deteriorated and ended. There are no further entries in the family liaison log.

69. The family told my senior family liaison officer that they were upset that they had not heard anything from the prison. The investigation team has examined the family liaison log and spoke with the prison FLO at the beginning of the investigation process to consider their concerns. NOMS offers guidance on how to conduct family liaison, entitled "Liaison with bereaved families following a death in custody guidance". It advises that it is the role of the family liaison officer to maintain contact with the family up until, and sometimes after the inquest. However, the guidance also explains that the FLO role is not a counselling role. It describes the FLO as the family's main point of contact in the prison to deal with any queries. According to her log, at the meeting on 27 March, the FLO told the family that they were welcome to contact her with any queries. There was no further contact from that part of the family until June. There is no evidence that the family tried to contact the FLO in the meantime, or vice versa.
70. I am disappointed that the prison's relationship with this family has broken down. The sensitivities around breaking the news, the first visit and the funeral were unavoidable given police advice, but nonetheless must have been upsetting for the man's family. It is unfortunate that the family were not clear about the FLO's role following their meeting on 27 March. I do not think it unreasonable that the prison FLO did not contact the family after that meeting, because she was waiting for the family to contact her with any questions.
71. There were four deaths in custody at Durham over a two month period. The investigation teams have examined the family liaison in all four cases. The arrangement was the same in those cases, in that the family were asked to contact the prison when necessary but were otherwise not contacted by the prison after the funeral took place. I understand that the man's family would have liked to be contacted by the prison. In some cases, contact from the prison without cause could be perceived as an unnecessary intrusion. I hope that the Governor will ensure that future family liaison arrangements are clearly understood by the family from the outset.

Staff support

72. The (A)SO told staff to gather in her office when they were no longer needed to attend to the man. She spoke with those involved and checked their welfare. The orderly officer who managed the prison that day attended the man's cell in that capacity, but afterwards was available to provide support for staff on the wing. At 7.15pm, staff participated in a hot debrief, to give them the opportunity to discuss what happened and raise any concerns.

73. A further debrief meeting was held by the Head of Safety and Decency on 18 March 2009. Again, staff involved went through what had happened. The orderly officer thanked all those involved in the response efforts for their “excellent team working skills and professional conduct”.
74. Unfortunately, Hotel One, as the emergency nurse for her shift, was called straight to another emergency so could not attend the hot debrief. It is regrettable that she had no time to recover from the man’s death. It is also regrettable that no healthcare staff attended the debrief on 18 March. I expect the critical role played by healthcare to be recognised by the prison. I hope that healthcare staff are encouraged to participate in opportunities to debrief after serious incidents.

The Governor and the healthcare manager should that ensure healthcare staff attend future debrief meetings after a death in custody.

ISSUES

Clinical care

75. The clinical reviewer was appointed by the local PCT to conduct a review into the clinical care the man received during his short time at Durham. He reviewed the man's medical records and met healthcare staff at the prison, alongside my investigator. Despite being unable to interview jointly staff with the investigation team, he saw all the relevant transcripts and notes of interviews to inform his review.
76. The clinical reviewer makes four recommendations in his review, which I endorse and refer to in the following sections. As well as identifying lessons that could be learned, the clinical reviewer also recognised good practice. It was his view that the prison "demonstrated efforts to ensure that prisoners with alcohol and drug problems are dealt with appropriately by trained professionals". (I discuss this in more detail below.) He also describes resuscitation efforts by healthcare professionals and officers as "exemplary". I will discuss his findings, along with my own, in the following pages.

Alcohol detoxification

77. The man told staff that he drank a litre of vodka and 12 bottles of beer a day. This was described by his CARATS worker as a "heavy" use of alcohol. Nevertheless, the prison doctor and the RMN, the substance misuse nurse, did not notice serious signs of alcohol withdrawal. The man told the RMN that he had never tried to stop drinking before. He then told the CARATS worker that he was pleased to be undergoing detoxification for the sake of his children. All the staff thought that he was honest about his substance misuse and genuinely wanted to stop drinking.
78. The man began the alcohol detoxification programme on 4 March. The clinical reviewer considered that the clinical treatment he received was appropriate to his needs. He was located on the induction wing for the majority of his time at Durham. This is in line with the prison's local Alcohol Management Strategy. However he was transferred to the larger 'A' wing on 11 March before the detoxification programme had been completed. No prison staff on that wing were aware that he was on a detoxification programme although he was being monitored by nursing staff when he collected his medication three times a day.
79. The clinical reviewer noted that the man was assessed by a trained substance misuse worker and mental health nurse and also by a member of the CARATS team who offered intervention, assessment and counselling. He concluded that this demonstrated the prison's efforts to ensure that prisoners with alcohol and drug problems are dealt with appropriately by trained professionals.
80. I am however concerned about the lack of both psychological and social support for prisoners going through detoxification. I understand that there

are limited national resources in this area. I am pleased that Durham has now introduced an Alcohol Strategy following the inspection from HMCIP in 2006. However, the document is limited to the clinical care, and still does not discuss the psychological needs of prisoners going through such a traumatic time.

81. The CARATS representative carried out an excellent substance misuse assessment, however there were little resources available for further support. I do not doubt that the man would have received support from CARATS through one to one sessions and group work in due course, should he have lived. I am concerned that so little was available to him throughout his detoxification which was nearing the end. In other investigations, the Ombudsman has found that when an individual ends the detoxification process, feelings masked by the use of illicit substances can be felt more strongly, and the reality of their situation becomes even more apparent. This makes the need for additional support even more important. This problem is not specific to Durham and it is imperative that efficient clinical detoxification is accompanied by support for prisoners to address the problems that might have led to their drinking.
82. Alcohol withdrawal affects a significant number of the prison's population. In other investigations that this office has undertaken in prisons throughout England and Wales, I have commented on the lack of resources for prisoners going through alcohol withdrawal before. This is the not the first time I have made this recommendation and I am concerned that I must repeat it again:

NOMS should consider allocation of funding to support the considerable number of prisoners going through withdrawal from alcohol in prison.

I agree with the Chief Inspector's finding that additional support is often easier when it is delivered on a specific unit. Staff on the unit where the man died were not aware he was withdrawing from alcohol. When prisoners going through detoxification, whether from alcohol or drugs, are located on one unit, specific interventions are more easily delivered, and non-clinical staff are aware without breaching medical confidentiality.

First reception healthscreen

83. The HCO who carried out the man's first reception healthscreen on 4 March was an experienced member of staff and referred him to the substance misuse team and to the doctor. (I will discuss the positive heroin result below.) As part of the assessment of the man's mental health, the HCO asked him whether he had ever self-harmed before. The man said that he had taken an overdose 18 months previously. If the member of staff does not open an ACCT document, even when a prisoner has self-harmed before, the form requires an explanation. In this section, the HCO has written, "No". When asked about this entry during interview, he said he would usually write

“no, ok now”, but could not remember why he had not done so on this occasion.

84. The man also told the healthcare officer that he had received treatment for depression from the doctor. Given his history of self harm and reported treatment for depression, the HCO was required to refer him to the mental health service. The emboldened instruction is clearly marked on the first reception healthscreen form. When asked why he did not make a mental health referral, the HCO said that he thought the man’s mental health could be appropriately treated by the doctor. In this case, the man was assessed by the doctor on the day of his arrival. The doctor referred him to the mental health team, so there would have been no delay in his mental health being assessed. Nonetheless, I am concerned that the HCO did not follow the clear instruction on the healthscreen form.

The Head of Healthcare should remind staff of the importance of following the clear requirements of the first reception healthscreen.

Mental health referral

85. The doctor made a routine mental health referral. He told my investigation team that “it does not usually take weeks” for a routine mental health referral to be processed. However, the healthcare administrator told the team that it can take between six and eight weeks for an assessment to take place.
86. The man told the HCO and the doctor that he had been diagnosed with depression and was receiving treatment for it. He was being prescribed Amitryptiline, which can be used as an anti-depressant. However, the dose that he was taking was too small to be an effective anti-depressant and was instead being prescribed for pain relief. His medical records, retrieved from his community practice after his death, show that he had not been diagnosed or treated for depression in recent years. I will discuss the retrieval of his medical records below.
87. The doctor told the investigation team that he made the mental health referral because of the history of depression and the man’s previous attempt at suicide. He did not consider him at risk of self harm, taking into consideration his body language at the time of his examination. The doctor thought it was “prudent” to make the referral, and described it as a “precaution” during his interview for this investigation. He seconded the HCO’s referral to the substance misuse team, and was assured that his needs would be met there as far as detoxification. I agree with the doctor that a routine mental health referral was appropriate given the information available at that time.

Positive heroin result

88. As part of the first reception healthscreen, the man’s urine was tested for illicit substances. Amongst other substances the healthscreen document was marked that his urine contained traces of heroin. All of the clinical staff

interviewed by the investigation team understood that of a positive heroin result did not necessarily mean that the prisoner had taken heroin, and it could mean he had taken an opiate based medication. However, the form itself is misleading as it quite clearly states that the positive finding is for heroin not opiates. His result reflected the codeine that he was taking for his arthritis.

89. The investigation team contacted the Department of Health's section head for substance misuse to confirm how the urine test could be interpreted. He agreed that any opiate would show in a routine urine test and could be recorded as a positive heroin result. However, he told the investigator that any positive result should be discussed with the prisoner. It is likely that staff were correct in their assumption that the man had not taken heroin, given he did not present symptoms of withdrawing from drugs, although he did appear to be withdrawing from alcohol. However, I share the clinical reviewer and the section head's concerns that the positive result was misleading and was not followed up by staff.

The Governor has accepted that the record heroin was present was not correct. He advised that they are looking at ways to improve the recording of first reception health screen results to more accurately reflect the information that they have. I agree with the clinical reviewer that, if possible, the urine test should discriminate between heroin and prescription opiates. With this in mind, I repeat the clinical reviewer's recommendation:

The Department of Health should consider revising the urine test at reception to discriminate between heroin and prescription opiates.

Missed secondary health check

90. The man was due to have his secondary health check on 10 March and the primary care team leader visited his cell on the induction wing to carry it out. However he had been taken to court by the time she arrived. The nurse marked in the records that she had seen him although she had not. Therefore, a follow up appointment was not booked for the following day in line with normal procedure. As discussed above, the clinical reviewer shares my view that the second health screening gives an opportunity to the medical department at the prison to review and assess the patient again.

The Head of Healthcare should devise a system to audit whether prisoners have received a secondary healthscreen.

Community medical records

91. The doctor's request for the man's records was written in capital letters. Although they were requested by fax on 5 March from the surgery, they were never received. My investigation team were told that missing records were normally followed up within 48 hours. The administrative assistant went on leave before the 48 hours had elapsed. No one covered her role in her

absence, so the community practice was not contacted when the records did not arrive until after the man's death.

92. I agree with the clinical reviewer that this is not acceptable. In the man's case, staff were not aware that he had not been diagnosed with depression or that he had not complied with his medication in the community. The investigation team interviewed the Head of Healthcare Administration who acknowledged that the system for retrieving records had failed in this instance.
93. I am pleased to report that Durham has improved its systems by using a database system to request records. This is a system which can be accessed by any member of the healthcare team meaning that outstanding requests for patients' medical records are monitored more closely and efforts are being made to improve communications with practices in the community. Given the improvements, I am not minded to make a recommendation in this matter.

Emergency response

94. The two officers who were closest to the man's cell when he was discovered hanging were not carrying radios because their duties did not require it. The second officer thought he was carrying a radio that day, but records show that his duties did not require it. The first officer remembered that neither officer had a radio with them at the time of the emergency. On balance, it is unlikely that the second officer was carrying a radio.
95. Although no one is clear who raised the general alarm, it was probably raised before the Code Black radio call was used. Although it is prison procedure to use a radio code system to communicate the nature of the emergency, the use of the general alarm had the intended effect of getting assistance to the man. I do not think the use of the general alarm unnecessarily delayed the emergency response.
96. The Hotel One response nurse heard the general alarm and then heard the request for medical assistance. She told the investigation team that she did not know the nature of the emergency because she did not hear the Code Black radio call. The investigation team spoke to several staff who attended the man's cell that day and they all recalled the Code Black radio call being used, albeit after the general alarm was sounded. Hotel One was nearby and had waited for further instruction when she heard the general alarm. The collection of medical equipment was not her role, but the role of the nurse that day. I do not think that Hotel One's confusion delayed her response to the emergency situation. The medical equipment was brought by the nurse within minutes of the alarm being raised. Neither do I think that confusion about the nature of the emergency delayed the man's access to emergency medical care.
97. However, I am surprised that the (A)SO took so long to reach the man's cell. I understand that she did not know what had happened when the general

alarm was raised. When a general alarm is raised, officers must ensure prisoners are taken back to their cells immediately to allow staff to deal with the emergency, stop the prisoners using phones, and preserve the dignity of individuals in need of attention. I also appreciate that it can be difficult to estimate how much time has passed during an emergency situation. However, I expect the senior officer of a wing to assist in an emergency situation on their wing as a matter of priority and delegate this task to officers.

98. It is unfortunate that so much confusion surrounds the sequence of events after the man was discovered. However, I agree with the clinical reviewer that the resuscitation efforts carried out on him were prompt and appropriate.

Family concerns

99. Following the issue of the draft report, the family's legal representatives forwarded my investigator a statement made by a prisoner that had been at Durham at the same time as the man. The statement concerned an exchange between the prisoner and the man when he was at Court on 10 March. In the statement, the prisoner described conversations with an officer and the SO, both based on D wing, about whether he could be transferred to D wing and shared his anxiety that he did not want him "to become another statistic".
100. My investigator spoke to the officer and the SO. Both officers remembered the prisoner who made the statement for the man's family. They described him as getting along well with staff. The officer did not remember speaking to the prisoner before the man's death, although he confirmed that he was working on D wing at that time. He said that he would have understood the reference to not wanting the man "to become another statistic" to mean that the prisoner thought the man might be at risk of suicide. The officer could not recall speaking to the prisoner or the first night centre about a possible wing transfer or the man's risk of suicide. The officer said that he would have spoken to someone on the first night centre where the man was located and asked whether a transfer would be appropriate, although no records are kept of such conversations.
101. The SO recalled that he managed D wing in March 2009. He said that he could not recall speaking to the prisoner about a possible wing transfer or the man's risk of suicide. The senior officer also agreed that he would understand the prisoner's reference to the man "becoming another statistic", as suggestive that the man was at risk of suicide. However, he would have assured my investigator that he would have acted on such information by speaking to the wing or to the safer custody team. He said that the man would have been eligible to transfer to D wing and such a wing transfer could be arranged, as long as there were no security reasons to prevent it.
102. The investigation team asked the prison to check whether there was any record of either the SO or the officer speaking to someone on the first night centre about transferring the man to D wing, or assessing his risk of suicide.

There were no records to this effect. Neither officer recalled speaking to the prisoner who made the statement. Both officers said that they would not necessarily write down a subsequent conversation because it would be the responsibility of the wing where the man was located to record such information in his files. However, both the SO and the officer were certain that they did not speak to the prisoner about the man's welfare. With such a dearth of records, it is not possible to determine whether these two conversations took place. Following her conversations with the officers in question, my investigator was satisfied that they understood the appropriate action to take if such concerns were raised with them. However, it is surprising that there seemed to be no requirement to record such a conversation in the record of the prisoner who raised the concerns.

103. Before the investigation was complete, the family raised concerns about the man's treatment for depression and the assessment of his risk of self harm. As discussed above, he was not recently diagnosed with depression and he was not receiving medication for his mental health. The medication he received in the community was prescribed at the same low dose, so was a painkiller, rather than an anti-depressant. Staff told the investigation team that they considered whether he was at risk. They described the body language they looked for, and were assured by his manner that he was not at risk of self harm. I must be careful not apply the benefit of hindsight in my investigations. Given the information that staff had when they made their judgement, and his presentation at the time of their assessments, I think they were reasonable in their judgement that he was not at risk of self harm.
104. The man's sister told the senior family liaison officer from this office that she spoke to officers about his depression after attempting to visit him on 8 March. She said she asked them to open a suicide watch. The investigation team spoke to the officers on duty in the visits area that day. They had no recollection of that conversation and no record was taken.
105. It is possible that the man's sister spoke to the volunteers (who are located at the front doors to direct visitors) although again there is no information recorded in any logs for that date. The importance of intelligence from a family member must never be underestimated. His sister was under the impression that her brother suffered from depression, even though his medical records demonstrate that he had not recently received treatment for his condition. Whether or not he suffered from depression, any such warning from a family member should be recorded. While it is impossible to determine what exchange took place on 8 March, I make the following recommendation:

The Governor should remind staff of the procedures in place when a relative or visitor raises a concern about a prisoner.

106. The man's sister was not allowed to visit her brother on 8 March because he had apparently already received two visitors that day. (In fact, the two prisoners visited two days before his sister's visit.) The family understood that prisoners on remand could receive as many visitors as they want to,

because they have not yet been sentenced. Prison Service Order (PSO) 4600 – Unconvicted, Unsentenced and Civil Prisoners provides the Prison Service instruction on what rules should be applied to prisoners on remand. In this PSO, it requires the following: “He/she can have as many visits and send as many letters as they wish, subject to practical limitations.” The PSO is silent as to what it considers to be reasonable “practical limitations”, although invites the prison to devise a local policy. Despite numerous requests for the local policy for visits, no such policy was sent to the investigation team.

107. PSO 4410 – Prisoner Communications – Visits, is more specific about the number of visits reasonably allowed for remand prisoners, as follows:

“each unconvicted prisoner must be allowed visits on at least three days a week, including the opportunity for a visit on Saturday or Sunday, normally every weekend and at least every fortnight”.

It must have been frustrating for the man’s sister to have travelled to the prison and not been able to visit her brother. It is clear from his records that he was visited on 6 March and his sister tried to visit him two days later, Sunday 8 March. I cannot determine whether officers were reasonable to refuse the visit on the morning of 8 March, because the investigation team has not seen the local visits policy. I hope that the Governor will satisfy himself that the visit was refused in line with local policy and, if not, take steps to prevent this happening in the future.

108. The man’s family were very concerned that news of his death reached their community before they were notified. The investigation team visited his cell and confirmed that there were telephones located outside his cell and one floor above. Prisoners on the telephone when he was found could have shared that information. The staff priority was to make efforts to resuscitate him. The (A)SO told the investigation team that prisoners were moved back into their cells as quickly as possible including those using telephones. It is regrettable that the man’s family might have heard about his death as a rumour before being formally notified.

CONCLUSION

109. The man was only at Durham for just over a week. His reception screening was not well recorded, but identified that his main problem was alcohol use. He received an appropriate detoxification, and was well assessed, but there was nothing available to support him through this physically and mentally stressful time. It compounds the importance of the missed secondary healthscreen.
110. He gave staff an incorrect medical history, claiming that he was being treated for depression. The prison's failure to retrieve his medical records meant that this crucial information was not known by staff until after his death. This might not have had a bearing on the overall outcome in this case, but would have certainly had an impact on his ongoing care.
111. I am satisfied that neither prisoners nor prison staff noticed any sign that he was at risk of harming himself or taking his life. My investigation has found no evidence as to why he might have done so, other than the nature of the alleged offence, and his alcohol withdrawal. The events of 12 March were confused, but the clinical reviewer confirmed that he received prompt and appropriate response efforts from staff. Regrettably, that did not change the outcome for him and his family.

RECOMMENDATIONS

1. The Governor and the healthcare manager should ensure that healthcare staff attend future debrief meetings after a death in custody.

This recommendation was accepted and healthcare staff were reminded of the importance of attending debrief meetings.

2. NOMS should consider allocation of funding to support the considerable number of prisoners going through withdrawal from alcohol in prison.

NOMS identified this as a matter for the consideration of the Department of Health and neither accepted or rejected this recommendation. Although the report was sent to the Department of Health for consultation, no response has been received.

3. The Head of Healthcare should remind staff of the importance of following the clear requirements of the first reception healthscreen.

The Head of Healthcare accepted this recommendation and has already addressed the matter through formal one to one meetings and the reissuing of guidance to staff.

4. The Department of Health should consider revising the urine test at reception to discriminate between heroin and prescription opiates.

As previously stated, the Department of Health has not responded to the investigation report and there is no indication whether they have accepted or rejected this recommendation.

5. The Head of Healthcare should devise a system to audit whether prisoners have received a secondary healthscreen.

The recommendation was accepted. A monthly Primary Care report is already in place to ensure that prisoners have received a secondary healthscreen.

6. The Governor should remind staff of the procedures in place when a relative or visitor raises a concern about a prisoner.

The Governor accepted this recommendation and set his response out as follows:

“Where information is received into the establishment from families, agencies, and other parties outside the establishment who have a concern for a prisoner who may be at risk of self-harm or suicide the SPC must record and pass the information to the area of the prison where the prisoner resides”

The Suicide Prevention Co-ordinator personally interviews the prisoner and, an immediate needs is undertaken following discussion.