

A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man in February
2013, while a prisoner at HMP Durham**

Our Vision

*'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision'*

This is the investigation report into the death of a man, who was found hanging in his cell at HMP Durham in February 2013. He was 22 years old. I offer my condolences to his family and friends.

A review of the man's clinical care while in custody was conducted. HMP Durham cooperated fully with the investigation.

The man hanged himself just hours after his arrival at Durham. The investigation considered whether he should have been identified as being at risk of suicide and self-harm when he arrived. Such assessments are not an exact science and involve balancing the prisoner's demeanour and behaviour against known risk factors. He had a history of depression, had harmed himself only two days before arriving at the prison and had said that he had thoughts of taking his own life. This information was clearly recorded on the custodial documents received at Durham but there is no indication that the information was fully taken into account when considering his risk of suicide or self-harm. I consider this was a serious omission. Whether this would have changed the outcome cannot be known but, as is too often the case, prison staff placed too much reliance on his personal presentation, rather than the known risk factors.

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.

Nigel Newcomen CBE
Prisons and Probation Ombudsman

November 2013

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SUMMARY

1. The man was born in September 1990. On 13 February 2013, he was remanded into custody on charges of robbery and sent to HMP Durham. He had a history of mental illness and self-harm and this was his first time in prison. While at court, he had told the custody officers that he had harmed himself only two days earlier and still had thoughts of taking his own life. This information was recorded in the custodial escort documents which accompanied him to the prison.
2. When the man arrived at Durham, prison staff signed the escort documents to confirm that they had received and read them. When asked by staff, he said that he had no thoughts of harming himself or taking his own life and staff decided he was not a risk to himself. He was not monitored under suicide prevention measures.
3. At approximately 9.45pm that evening, staff found the man hanging in his cell and called for emergency assistance. Staff began cardio pulmonary resuscitation (CPR). An emergency ambulance was requested at 9.54pm and paramedics arrived at his cell six minutes later. After a period of assessment and emergency treatment, they confirmed that he had died.
4. The prison family liaison officer contacted the man's family and offered appropriate support and financial assistance towards the funeral expenses.
5. The man had known risk factors which increased his risk of self-harm and suicide. We conclude that information alerting staff to these risks was not sufficiently considered and that the information should have led prison staff to conclude that he needed to be monitored under prison suicide and self-harm prevention procedures. After he had been found, there was a delay in calling an emergency ambulance. We make recommendations about the assessment of risk and the need to call ambulances more quickly in an emergency.

THE INVESTIGATION PROCESS

6. The investigator visited Durham on 20 February 2013 and was given copies of all documentation relating to the man. He met the Deputy Governor. Notices were issued to staff and prisoners inviting anyone with information to contact the investigator. No one came forward as a result. The investigator subsequently interviewed ten members of staff. Written feedback about our preliminary findings was given to the Governor on 12 March.
7. The local PCT appointed a clinical reviewer to review the man's clinical care.
8. The investigator contacted Her Majesty's Coroner to inform him of the investigation and request a copy of the post-mortem report.
9. One of our family liaison officers contacted the man's family about the investigation and to invite his family to identify any issues which they wished the investigation to consider. His family believed there was poor communication between the police and the prison about his risk of self-harm and wanted to know why he was in a double cell on his own. The report covers these points. The family received a copy of the draft report. They did not raise any further issues or comments on the factual accuracy of this report.

HMP DURHAM

10. HMP Durham is a local prison serving the courts of Tyneside, Durham and Cumbria. It holds up to 1017 men. Healthcare is provided by a private healthcare provider on behalf of the local Primary Care Trust.

HM Inspectorate of Prisons

11. The most recent inspection by HM Inspectorate of Prisons took place in October 2011. Inspectors found there were significant levels of self-harm, with over 250 incidents in the nine months before the inspection. There was good strategic management of safer custody but the quality of suicide and self-harm documentation was variable. The report identified a need for improvements in suicide and self-harm prevention procedures.

Independent Monitoring Board (IMB)

12. Each prison has an IMB of unpaid volunteers from the local community who monitor all aspects of prison life to help ensure that proper standards of care and decency are maintained. In its most recent annual report, the Board noted:

“E Wing is a first night centre where prisoners generally stay for four to seven days. Induction is started in Reception where all prisoners are seen by a nurse, doctor and psychiatric nurse. If this is their first time in prison or they are vulnerable, they are seen by one of the two ‘meet and greet’ prisoners.

“On arrival at HMP Durham all prisoners are clinically assessed for both their general and mental health status.

“At HMP Durham all newly arrived prisoners identified as having mental health problems are referred to the mental health team, which now has ten members, who triage their case and refer them to the most appropriate clinician – Psychiatrist, GP or CPN.”

Previous deaths at HMP Durham

13. In the previous 12 months there has been one other self-inflicted death at Durham, in May 2012. There are some similarities between the circumstances of that death and the man’s death. In both cases it was the prisoners’ first time in custody and there was a delay in calling an emergency ambulance.

KEY EVENTS

14. The man was born in September 1990. On 12 February 2013, he was arrested, charged with robbery and held in police custody. The next day, he appeared at Magistrates' Court. He told custody officers that he had harmed himself in the previous two days and had thought of ways of killing himself. Custody officers recorded this information on the Person Escort Record (PER) form and on a Suicide and Self Harm Warning (SSHW) form. These are documents intended to alert all criminal justice agency staff who come into contact with prisoners about their risk.
15. On 13 February, the man was remanded into custody at HMP Durham and scheduled to re-appear in court on 20 February. This was his first time in prison. The PER and SSHW forms accompanied him to Durham.
16. When he arrived at the prison, at approximately 1.45pm, a Senior Officer (SO) met him and signed the PER and SSHW forms to record that they had been received and read. The SO said at interview that he was aware of what had been written on the forms but he had chatted and joked with him, who gave him no cause for concern that he might harm himself. A Cell Sharing Risk Assessment (CSRA) was completed, and he was assessed as being a high risk to others because he said he had racist views, which meant he would not share a cell.
17. A nurse saw the man for an initial 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, any substance misuse matters that need to be addressed, and any risk that the prisoner may pose of harming himself or attempting suicide.) The nurse signed the PER form to show that he had read it. He told the nurse that he suffered from depression and had been prescribed medication by his community doctor. He also said that he used to drink up to five cans of strong lager a day. He told the nurse he had no current thoughts of harming himself. The nurse referred him to be seen by the prison doctor and the mental health team.
18. At interview, the nurse told the investigator that, as a nurse working in reception, he was required to screen each new prisoner and follow a template on the computerised medical records. (The template lists a series of questions designed to establish the state of a prisoner's physical and mental health, and to identify any substance misuse and self-harm issues. Prisoners are referred to the doctor or detoxification and mental health teams as appropriate.)
19. The nurse told the investigator that he had signed the PER form and had read that the man had said he had been thinking of ways to kill himself. The nurse saw that his arms had cuts on them, which he said were superficial and did not need stitches. The nurse said that he seemed very calm and composed, not tearful or anxious, although he appeared angry at being in prison. The nurse did not think that he needed to open an ACCT document (the tool used

to support prisoners at risk of suicide or self-harm) and he said the man said he had no thoughts of self-harm or suicide. He referred him to the doctor because of his level of alcohol consumption and the mental health team regarding his depression.

20. A doctor saw the man that evening and assessed that he did not show any signs of alcohol withdrawal. The doctor said at interview that the man said that he did not have a drink problem and did not use drugs. The doctor said that it had been difficult to engage with him but that he did not indicate that he intended to harm himself or take his life.
21. The man moved from reception to the induction wing and saw an officer, who completed the induction paperwork. The officer told the investigator that the man gave no indication that he had any thoughts of harming himself. He was allocated to cell E1-006 which he occupied on his own because of his cell sharing risk assessment.
22. Prison phone records show that the man called his partner at 7.20pm, for one minute and 12 seconds, and again at 7.24pm, for two minutes and 20 seconds. He also called his step-father at 7.27pm and that call lasted for four minutes and 14 seconds. We have been unable to listen to these calls as the prison has informed us they were not recorded.
23. The officer on duty on the induction wing until 8.00pm told the investigator that the man appeared anxious and tearful when he spoke to him at approximately 7.50pm. However, he said he had no concerns about his well-being as he had made his bed up and was going to watch television. Nevertheless, the officer asked the night duty officer to keep an eye on him.
24. The night duty officer said he checked on the man at approximately 9.20pm when he was standing by his bed watching television. He said that he told him he was all right.
25. At 9.45pm, a nurse and a Healthcare Support Worker (HSW) were conducting routine checks on new prisoners when they came to the man's cell. The nurse looked into the cell and saw him suspended from the top bunk of his bed by a shirt. She radioed "emergency – ligature cell E1-6 Level 1" and ran to fetch the resuscitation equipment from the medication room on the wing. She explained at interview that healthcare staff do not have cell keys at night, so they were unable to go into the cell straight away.
26. Two officers immediately responded to the alarm and went into the cell. One officer supported the man's body while the other cut the shirt using his anti-ligature knife (a specially-designed knife carried by all officers). Both officers lowered him to the floor. By this time, the nurse and HSW had returned with the emergency equipment and immediately started CPR. They were joined by another nurse. An automatic external defibrillator (AED - which monitors the heart rhythm and administers electrical shocks to the heart to restore the normal rhythm when necessary) was used. The AED advised that there was no shockable rhythm.

27. The Acting Principal Officer (APO) had responded to the emergency call and when he arrived at the cell found the healthcare staff already conducting CPR. He said at interview that he established with a nurse that an ambulance had not been requested and radioed to contact the control room to request an emergency ambulance. The 999 call was made at 9.54pm.
28. Healthcare staff continued with CPR until the paramedics arrived at the cell 10.01pm and took over the man's care. Following emergency treatment and assessment, at 10.34pm, the paramedics pronounced that he had died.
29. As with all deaths in custody, the police undertake an initial investigation to check whether a criminal investigation is necessary. They found a note in the man's cell, written jointly to his step-father and partner, in which he said that he was sorry but he was unable cope anymore and there was too much pain in his heart to carry on.

Contact with the man's family

30. The Duty Governor and an officer visited the man's nominated next of kin, his step-father, in the early hours of 14 February to break the news of his death. In the following days, Durham maintained contact with the family to offer support and financial assistance toward funeral expenses.

Support for staff and prisoners

31. A hot debrief was held that night for staff involved in the emergency incident to discuss what had happened and to offer support. The services of the care team were made available.
32. Officers and members of the chaplaincy were available to support prisoners affected by the incident. Prisoners subject to suicide and self-harm monitoring had their ACCT reviewed in case they had been adversely affected by the man's death.

ISSUES

Assessment of risk

33. Prisoners who are regarded as at risk of suicide and self-harm are managed under a system known as Assessment, Care in Custody and Teamwork (ACCT). Any member of staff can start the ACCT process, by raising a Concern and Keep Safe form, explaining the reasons for their concern. An Immediate Action Plan is written by the manager of the wing where the prisoner is located and, within 24 hours, an ACCT assessment should be carried out by a member of staff who has the required training. Once placed on an ACCT plan, the prisoner is subject to regular case reviews that will direct the level of observations and conversations to be carried out at intervals determined by their perceived level of risk.
34. Staff judgement is fundamental to the ACCT system. At its core, the system relies on staff using their experience and skills, as well as local and national assessment tools, to determine risk. They must balance this against the prisoner's known risk factors and their presentation.
35. Prison Service Instruction (PSI) 64/2011 states that "all staff who have contact with prisoners must be aware of the triggers that may increase the risk of suicide, self-harm or violence, and take appropriate action". A list of potential triggers includes previous deliberate self-harm, mental illness and early days in custody.
36. The man had several such risk factors indicating that he was at risk of suicide or self-harm. He had recently harmed himself, had declared thoughts of taking his life, had suffered from mental illness and was in custody for the first time. These factors were known to staff at the prison when he arrived at Durham. A prisoner's presentation is obviously important and reveals something of their level of risk. However, it is only a reflection of their state of mind at the time they are seen by the member of staff and should be considered as a single piece of evidence used to make a judgement of risk. All risk factors must be collated and considered to ensure that a prisoner's level of risk is holistically judged. We conclude that the risk factors were sufficiently apparent at the time to indicate that an ACCT plan should have been opened. Too much reliance was placed on his personal presentation rather than the known risks which had been detailed on the escort documents. We make the following recommendation:

The Governor should ensure that all the known risk factors of a newly-arrived prisoner are fully considered when determining their risk of suicide and self-harm and that an ACCT is opened when there is an indication that the prisoner is at risk.

Clinical care

37. The clinical reviewer makes the following comment in his report:

“Reception screening on the man’s arrival at HMP Durham indicated that he had no long-term medical problems, but he admitted to self-harming by cutting his forearms two days earlier. He reported drinking approximately 100 units of alcohol a week in the form of Special Brew (strong lager).

“He denied taking any other drugs than alcohol for recreational purposes.

“The record shows that he said that he had seen a psychiatrist several years previously and that he had been prescribed an antidepressant (possibly citalopram), but that he was not prescribed any mental health medication at the time of reception.

“The record shows that he had seen a doctor outside prison for reasons of “mental health”. A nurse made a referral to the mental health team and arranged for the patient to see the duty GP the same evening.”

38. As the man was seen by healthcare staff late in the afternoon on the day of his arrival at Durham it would have taken a further 24 hours to obtain his community medical records. We are therefore satisfied that the clinical care he received was to the standard expected when a prisoner arrives in custody for the first time and that referrals to specialist staff were appropriate.

Emergency Response

39. Healthcare staff responded swiftly on finding the man. The clinical reviewer commented that “extensive and prolonged resuscitation efforts are documented with the use of appropriate equipment”. There was, however, a nine minute delay before an emergency ambulance was called.

40. At the time of the man’s death, Durham already had in place a local protocol for calling an ambulance. The protocol had been issued to staff in October 2012, and specifies the emergency codes to be used to summon urgent medical assistance. In particular, “Code Black” should be called, over the radio or by phone, when a prisoner is found unconscious or non-responsive, giving the location and number of prisoners involved. The control room should then immediately call for an emergency ambulance. The protocol goes on to state:

“An ambulance must be summoned immediately by the control room when a code black alarm is raised and not wait for confirmation from health care staff once they are at the scene.

“Access may be required at any time of the day or night and is therefore important that all staff are aware of the action to be taken in the event of an emergency call.”

41. On discovering the man hanging in his cell, the response nurse did not follow Durham’s protocol for requesting an emergency ambulance. When interviewed, she told the investigator that she had not used code black over

the radio and did know what each of the coded requests were, what they meant and what actions would take place as a result.

42. An ambulance was not called until the APO asked the nurse if one was required, after CPR had started. This was nine minutes after she had initially radioed for assistance. While it is not evident that a quicker assessment by paramedics would have made a positive difference to the outcome in the man's case, it is important that an ambulance is called immediately in an emergency. This requirement is now also contained in a national Prison Service Instruction (PSI 03/2013/Medical Emergency Response Codes) which came into effect shortly after his death. We have previously highlighted this issue at Durham, before the protocol was issued. However, it seems that the provisions of the protocol are not yet embedded in practice. We therefore make the follow recommendation:

The Governor should ensure that all staff fully understand and adhere to protocol for the use of emergency codes and that an ambulance is called automatically in such circumstances.

RECOMMENDATIONS

1. The Governor should ensure that all the known risk factors of a newly-arrived prisoner are fully considered when determining their risk of suicide and self-harm and that an ACCT is opened when there is an indication that the prisoner is at risk.
2. The Governor should ensure that all staff fully understand and adhere to protocol for the use of emergency codes and that an ambulance is called automatically in such circumstances.

ACTION PLAN: The Man – HMP Durham

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Governor should ensure that all the known risk factors of a newly-arrived prisoner are fully considered when determining their risk of suicide and self-harm and that an ACCT is opened when there is an indication that the prisoner is at risk.	Accepted	<p>When arriving in reception any prisoner showing signs of distress, or signs that they may self harm, consideration will be given to opening an ACCT. This will be completed after consultation with the reception and medical staff, to ascertain the full risk factors.</p> <p>All information will be completed on the concern and keep safe form. This information will be considered by first night centre band 4 managers when completing the immediate action plan. This is to ensure that the person in distress receives appropriate support and located accordingly.</p> <p>All obtained information which has been entered on the concern and keep safe form will be entered onto C-Nomis case notes by Induction Unit night staff.</p> <p>This will be monitored by the Safer Custody team during their daily checks.</p>	1 st Sep 2013	

2	The Governor should ensure that all staff fully understand and adhere to protocol for the use of emergency codes and that an ambulance is called automatically in such circumstances.	Accepted	<p>A global email will be issued to all staff reminding them of the emergency codes, protocols and procedures.</p> <p>The protocol will be added to the agenda of monthly staff meetings, to reiterate the correct procedures required in cases of emergency.</p> <p>Re-issue Governors Notice to staff.</p> <p>All staff working within the ECR are now fully aware of the correct procedures following a Code Blue emergency and that an ambulance should be called immediately.</p>	1 st Sep 2013	
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