

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

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

December 2011

This is the report of an investigation into the circumstances surrounding the death of a man at HMP Durham who was found hanging in his single cell in May 2009. He was 23 years of age.

I extend my sincere condolences to his family and partner.

The investigation was conducted by one of my colleagues. I should like to thank the Governor of Durham and his staff for their co-operation throughout this investigation.

The man had been remanded into Durham in March charged with the murder of a neighbour. This was his first time in custody and it is clear that he found prison difficult. He had been maintained on suicide prevention monitoring and support measures (the ACCT process) during two separate occasions during his time in Durham. However, by the time of his death he was not being monitored as staff felt that he was no longer at immediate risk.

After the man's death suicide letters were found in his cell addressed to his parents and his partner. He had also left an account of his final few days in which he listed many concerns and complaints about the prison wing where he was located.

The first draft of this report was issued in February 2010. In response to extensive comments received from the man's family, I have made a number of revisions to this report which I reissue as a revised draft.

I make five recommendations. Four of these are about the ACCT process, two of which are national recommendations. The other recommendation is about guidance for Family Liaison Officers.

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 the investigation.

Thea Walton
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December 2011

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SUMMARY

The man was a 23 year-old prisoner who was found hanging in his single cell at HMP Durham on the early morning on a day in May 2009. His was the fourth self-inflicted death in Durham within a ten week period.

This was the man's first time in prison custody. He had been in Durham for just under two months and was there on remand having been arrested following an incident that resulted in the death of a neighbour.

On his arrival in Durham, the man told staff that he had harmed himself in the past and that he was having current thoughts of self-harm or suicide. Staff opened an ACCT¹ form and he was initially located on Durham's induction wing. The following day he was relocated to the healthcare unit for enhanced observation. That included a period of a week when he was kept on constant observation.

While in healthcare the man had consultations with a Community Psychiatric Nurse and with a Specialist Psychiatric Registrar (SpR). The man told the SpR that he had been an anxious child and had been bullied at school. He told her that he had started to harm himself while still in secondary school and also told her that he had always wanted to kill himself.

By the middle of April the man had settled and the ACCT form was closed. A week later, he was transferred back to E wing to complete his induction. During his time back on E wing the ACCT form was reopened after he was found lying under his bed in a tearful state.

Once induction was completed the man needed to be transferred to a residential wing. He was allocated to D wing, which is used primarily, but not exclusively, for prisoners with drug addiction problems. This man had no such problems.

The man's ACCT form was closed four days after his arrival on D wing when the review panel concluded that he was no longer at immediate risk. The panel did not read an entry in the ACCT form made two days earlier when he reported making a ligature at some time in the previous two weeks.

On Friday 15 May the man reported to a senior officer that he was fearful of the other prisoners on D wing. The senior officer took his complaint seriously and told him that he would arrange his transfer to a different, and more suitable, wing. He said though that he would probably not be able to arrange the transfer until the following Monday.

During the early morning roll check on a day in May the man was observed to be lying face down on the floor with a ligature around his neck tied to the top bunk. Staff went into the cell and examinations showed that rigor mortis was already established in his body. Consequently staff appropriately made no attempts to try to resuscitate him.

¹ ACCT (Assessment, Care in Custody and Teamwork) is the process used for monitoring and supporting prisoners deemed at risk of self-harm or suicide.

Following the man's death a journal was found in his cell in which he had recorded the events and his thoughts during the final few days of his life. It is clear from the journal that he felt frightened and intimidated by the other prisoners on D wing. He also referred to his conversation with the senior officer and that officer's promise to move him to a different wing.

THE INVESTIGATION PROCESS

1. My investigator in this case was assisted by one of my Assistant Ombudsmen. My investigator first visited Durham on 21 May 2009 when he met the Deputy Governor, the functional Governors in charge of safer custody and decency, a representative from the Prison Officers' Association and a member of the Independent Monitoring Board.
2. My investigator met the police investigator and agreed with him the handling of the complaints made by the man about the prison.
3. County Durham Primary Care Trust agreed to carry out a review of the man's clinical care and treatment at Durham. The PCT commissioned a private company, Custodial Care Innovative Solutions (CCIS), to conduct the review on its behalf. CCIS appointed a clinical reviewer to conduct the review. I would like to thank CCIS and the clinical reviewer for their assistance.
4. My investigator interviewed 14 members of staff. He interviewed one prisoner, a Listener² to whom the man had spoken a few days before his death. My Assistant Ombudsman joined the investigator for some of the interviews. No other prisoners came forward in response to the posting of notices about the man's death.
5. One of my Family Liaison Officers contacted the man's parents and she and the investigator visited them at their home. The man's sister and partner were also at the meeting.
6. The man's mother raised a number of concerns. She wanted to know about staffing levels on D wing and about the training that staff had received. She wanted to know whether there were any similarities in the circumstances surrounding her son's death and those surrounding the deaths of three other prisoners at Durham during early 2009. She also wanted to know whether her son had had a promise that he could move to the prison's healthcare unit if he wanted to. She questioned why Durham did not have a unit for vulnerable prisoners. She was also concerned about the way the family was dealt with following her son's death.
7. My investigator and family liaison officer also met the man's grandmother. With other members of the family she had visited her grandson on the day before his death when she thought he seemed his usual self. She also said, however, that he hated D wing and wanted to transfer back to healthcare. She said that she had observed a gradual deterioration in her grandson. She had once believed in the British justice system but was losing that faith. The man's grandmother thought he had been let down by everyone and she wanted it known how much his death had affected the entire family.

² Listeners are prisoners trained by the Samaritans to provide the same service as Samaritans offer in the community.

Family response to revised draft report

8. In response to the Ombudsman's first draft report, the man's family raised a number of additional questions. In order to address these questions a revised draft report was issued. In response to the Ombudsman's revised draft report, the man's family provided further comments through their solicitors. The response mainly centred on three major themes. The first theme was on information available on observation of CCTV footage. The investigator had only been provided with a copy of footage taken during the last 24 hours of his life and understood that that was the only footage that was available. However, the man's mother, in company with her solicitor, attended the prison and viewed footage taken from midday on 12 May through to 18 May. From their observations, the family and solicitor noted many more occasions when other prisoners were at the man's door compared to what the investigator observed from his more restricted viewing. The family and solicitor also pointed out that on some of these occasions prisoners were at the door in full view of officers and on one occasion a prisoner can be seen bending to take an item from underneath the man's door, which he then puts into his back pocket. The impact on the man of other prisoners appearing at his door is covered in paragraphs 95, 96 and 114. The additional information gleaned afterwards by the solicitor does not substantively change the conclusions that are drawn therein.
9. The second theme upon which the family have commented was on the closure of the ACCT plan on 14 May. From their observation of the CCTV footage the family and solicitor have pointed out that the man was unlocked from his cell at 10.57am and then locked back into his cell at 11.03am. They point out that this means that the ACCT review was completed in just a few minutes. They invited the investigator to re-interview the staff in light of this evidence before finalising the report. We did not consider it necessary to take up this invitation. This is because we were, in any case, critical of the fact that the ACCT plan was closed without the staff having familiarised themselves with daily entries in the man's ACCT plan since the previous review. This recommendation has been accepted by the service.
10. The third theme was the man's placement onto D wing. The family and solicitor have said that the report does not fully explain how the transfer to D wing took place and whether sufficient account was made of his particular needs before he was transferred. The investigation found that the most likely reason for the transfer was the need for the man to be placed in a single cell. The investigation also found that there was no particular reason at the point of transfer for staff to believe that he should not go to that wing. The family and solicitor have said that the CCTV footage of his time on D wing contradicts one of the findings in the report that there was only one established occasion when he complained formally to staff about being bullied. However, as the CCTV recording is silent we cannot be certain about much of what is actually occurring.

11. The family and solicitor have asked about similarities between other deaths at Durham and that of this man. Relevant information about this is contained in paragraphs 23, 93 and 94 of the report.
12. The concluding remarks made by the family and solicitor were to question the Ombudsman's conclusion about whether there was any more that Durham could reasonably have done to have prevented the man's death. They consider that there was more that the prison could have done. In making that point they refer to omissions with the ACCT process, the failure to pass on information about a doctor's entry in the ACCT plan, the placing of him onto D wing and not expediting, more speedily, his transfer off that wing. These issues are covered in paragraphs 99 to 108, 110 to 115 and 122 of the report and the conclusion of the investigation remains unchanged as a result of the family's comments.

HMP DURHAM

13. HMP Durham is a Category B local prison built in the early 19th Century. It serves the courts in the local area and it holds just under 1,000 prisoners.
14. The prison comprises seven wings as well segregation and healthcare units. E wing is the induction wing and D wing is used mainly for prisoners on the Integrated Drug Treatment Scheme (IDTS). The principle of IDTS is to bring together the counselling and support aspect of drug treatment with the prescribing and provision aspect.
15. Following a full announced inspection of Durham in September 2006, Her Majesty's Chief Inspector of Prisons published a report which included the following findings:

“Like all local prisons, Durham suffered from a lack of sufficient, and useful, activity. There were only 60 full-time education and 310 work places ... on one day of the inspection, we found 400 of the prison's 913 prisoners locked in their cells. This is, of course, partly a consequence of a prison that is operating 55% above its normal accommodation ...

“... Support and interventions were available if bullying was identified. However, there was a considerable amount of undetected bullying and intimidation of some vulnerable prisoners, who were mixed with other prisoners ...

“The prison had no vulnerable prisoner unit³ and operated a so-called ‘non-collusive regime’ in which prisoners of all types, regardless of their offence, mixed in all areas of the prison ... 43% of prisoners surveyed reported that they had felt unsafe at some time, and [23%] said they felt unsafe at present ... Discreet interviews with prisoners who would normally have been held in separate vulnerable prisoner units revealed significant under-reporting of bullying and victimisation ... as a consequence a number of prisoners ... were afraid to leave their cells.

“The systems to identify and support prisoners at risk of self-harm were generally of a good standard. Most suicide and self-harm support and monitoring forms demonstrated a thoughtful and caring approach ... However ... despite the fact that there had been nine deaths in custody in recent years, some of the recommendations resulting from the subsequent inquiries had not been implemented ...

“... the proportion of prisoners reporting that most staff treated them with respect matched that of comparator prisons. In group discussions, prisoners reported that the staff were one of the best things about the prison. This was confirmed by our observations ... we found the staff ... friendly and open both towards prisoners and each other. Staff we met were generally

³ Vulnerable prisoners are those who might be at risk from other prisoners, usually due to the nature of their offences.

cheerful, interested in their prison, and keen to work towards making it a decent and purposeful place.

“... Staff talked to us about prisoners in respectful and understanding terms on most occasions. However, on one occasion inspectors heard a group of staff discussing some prisoners in derogatory terms when they presumed themselves to be out of earshot.

“... Prisoners were encouraged to use [out of cell] association periods, and on some wings records were kept of prisoners remaining in cell and they were asked why. But not all wings followed this practice, and we were concerned that many vulnerable prisoners were afraid to mix ...”

16. The Inspectorate carried out an unannounced inspection of Durham in October 2009. The report of this inspection is still at draft stage but I understand that it will reflect much more positive responses from prisoners on the question of safety. Prisoners at Durham reported feeling safer on average when compared to those at similar establishments.

17. In their report for the year 2007 to 2008 the Independent Monitoring Board (IMB) referred to overcrowding at Durham with many prisoners having to share cells originally designed to hold just one prisoner. The IMB also commented:

“The prison’s budget in 2008/9 was set at £22.8 million. During the year the prison has been expected to contribute to [National Offender Management Service] savings targets and this has been done through the centrally imposed changes to the prisoners’ daily routine (the Core Day). It is understood that for the next few years the prison will receive the same budget meaning that any staff and non staff inflation will need to be funded through savings ...

“Throughout the period of this report HMP Durham has retained its level 3 status in the Prison Service’s performance ranking. This implies that the prison is ‘meeting the majority of targets, experiencing no significant problems in doing so, delivering a reasonable and decent regime.’”

18. The Prison Service’s performance ranking system referred to in the IMB report is a quarterly data driven performance assessment for each prison. The assessment results in prisons being rated at one of four levels: rating 4 equals exceptional performance; rating 3 equals good performance; rating 2 equals development required; rating 1 equals serious concerns. Durham’s rating remained at 3 following the period covered by the IMB’s report and remained at 3 for the time the man was there.

19. The man’s death was the 10th apparently self-inflicted death in Durham since I took on the responsibility for the investigation of all deaths in prison custody in April 2004. In two further cases prisoners contributed to their deaths through their actions but their ultimate intentions were not entirely clear. Durham had a particularly difficult time in the early part of 2009 with this man being the fourth self-inflicted death within a ten week period. Of these four prisoners, three,

including this man, had been on ACCT monitoring up to or close to the time of their death. Otherwise, there are few similarities in the circumstances of this man's case and the other three.

KEY FINDINGS

20. In January 2008, the man was referred by his general practitioner (GP) to his local community psychiatric team. The GP wrote that he had longstanding problems with low mood, poor self-esteem and poor coping skills. The GP also wrote that he had told him that he had a constant feeling of “not wanting to exist”.
21. Following the GP’s referral, the man had regular consultations with a community psychiatric nurse (CPN). Following a referral by another CPN, he was assessed by a consultant psychiatrist in September 2008 who then wrote to his GP practice saying:

“... There were no thoughts of self-harm at the time of interview although he reported the future as being ‘pretty glum’. He did not see that anything was likely to be particularly helpful to him.

“... [He] is a 22-year-old man with a lifelong history of dysthymic symptoms (chronic low mood) ... and a history since his teens of ... episodes of deliberate self-harm ... there were no associated features suggestive of a depressive episode, rather his symptoms appeared to be associated with his personality and a difficulty taking responsibility for himself. As such, medication is likely to be of symptomatic but otherwise limited benefit.”
22. On 20 March 2009, the man was arrested at home and charged with murder. The victim was one of the other residents at the flats where he was living. He spent three nights in police custody until 23 March, when he was remanded from magistrates’ court to HMP Durham.
23. Part of the prison reception process is completion of a first reception health screening assessment. During the assessment, the man revealed a history of self-harm as well as having current thoughts of self-harm or suicide. He also said that he had received treatment for depression. In response, staff opened an ACCT form for him to be monitored and supported in view of the risk that he might harm himself. He was also asked about his physical health but he denied having any problems.
24. Another aspect of the reception process is the cell sharing risk assessment. As the name suggests, this assesses a prisoner’s suitability to share a cell. Staff are instructed to make best use of documentary evidence in support of their decisions. The process includes early identification of racist, homophobic or violent prisoners to help protect potential victims. The process does not provide an actuarial risk score and does not replace staff judgement. There are three levels of risk: high, medium and low. There are two parts to the assessment. The first part is completed by a reception officer. The second part is completed by a member of the healthcare team who makes his or her own separate assessment. The locating officer will then allocate the prisoner to a cell and will base their decision on the information recorded on the cell sharing risk assessment form. In this man’s case the reception officer decided that his risk was medium, but the healthcare worker’s opinion was that his risk was low.

The locating officer that day decided that he was low risk for cell sharing purposes. She went on to endorse his ACCT to say that he should be located in a double cell so that he could have support from another prisoner.

25. The man's induction paperwork was marked to show that he was offered a free telephone call, but he declined the offer. The paperwork also indicates that he was informed about, and introduced to, the wing Listeners and the Meet and Greet Orderlies⁴. Once the reception process was completed he was located into a shared cell on E wing (Durham's induction wing). While there he was asked whether he had any immediate needs for issues to do with legal or probation matters. He said that he had no such immediate needs.
26. The next day, the man was moved to healthcare for observation of his mental health state. A 'Cell Sharing Risk Minimisation Plan' – another aspect of the cell sharing risk assessment process – was noted to say that he was high risk for cell sharing purposes and should be located into a single cell. The explanation given for this was that he seemed to have 'mental health issues', was 'potentially volatile' and had been charged with murder. It is not clear why these latter two issues did not lead to him being assessed as high risk when the cell sharing risk assessment was initially completed on 23 March.
27. Durham's suicide prevention co-ordinator told my investigator that he first met the man in healthcare on 24 March for an ACCT assessment interview. (The ACCT process includes a detailed interview to be carried out within 24 hours of the form being opened.) He said that his impression of the man at that meeting was that he was a very shy individual whose overriding concern appeared to be a belief that he had let down his family and partner in committing the alleged offence. He was very forthright in answer to direct questions although he did not elaborate on his answers. He revealed a history of previous acts of self-harm as a way of relieving stress. While he denied any immediate plans to take his life he also indicated that he could not see any future with a life in prison.
28. On the afternoon of 24 March the man attended an initial ACCT case review. One of the purposes of the initial case review is to devise how the person can best be supported. The support plan is then set out on a document known as a caremap⁵. The man's caremap contained the following two actions:

"Assessment by a psychiatric nurse.

"Support through visits, telephone contact and letters with his family."
29. A Community Psychiatric Nurse (CPN) told my investigator that she worked for the prison In-Reach team. She first met the man on 25 March after his transfer to the healthcare unit. She had been asked by the nurse in charge to see him due to concerns about his mental health. She said that when she met the man

⁴ Meet and Greet Orderlies, otherwise known as Insiders, are prisoners who speak to new arrivals in reception or induction to provide information for first time prisoners about life in custody.

⁵ A caremap specifies the actions to be taken to address the most urgent precipitating problems leading to a prisoner's thoughts of suicide or self-harm.

she found him to be pleasant and co-operative. She said that this was his first time in prison and he came from a “good family” so he was not a “typical prisoner”.

30. The CPN said the man was shocked and confused about what he had done. She found no evidence that he was psychotic. He said, however, that from a young age he had felt anxious, different to others and socially excluded. He had been bullied at school. For a long time he had considered suicide to be an option. He said that he started to self-harm from the age of 14. He would either cut or burn himself although he did not understand why. The CPN’s note of the consultation included the following plan:

“... discussed with [doctor], although no evidence of psychotic phenomena needs to be assessed by a forensic psychiatrist ... I will continue to engage with him to try to build up a relationship and continue assessing him. He remains on an ACCT as still at risk of harm to himself.”
31. The nurse in charge of healthcare told my investigator that she chaired several ACCT case reviews on the man. One of the reviews she chaired was on 28 March which had been brought forward as the man revealed that he was having constant thoughts of ending his life. The review panel decided that he should be placed under constant supervision. (With constant supervision a prisoner is supervised by a designated member of staff on a one to one basis. The member of staff will keep the prisoner within eyesight at all times and will remain within a suitable distance to physically intervene quickly if necessary.) This step was added to the man’s caremap with another addition to encourage him to become involved with the regime in healthcare.
32. On 28 and 29 March, a senior officer spent time with the man during his period on constant supervision. The senior officer told my investigators that he had spoken with the man and he felt he had established a rapport with him. The man was quite chatty and it seemed to the senior officer that he wanted to talk with someone. He spoke about where he lived, about his girlfriend and the rest of his family. He mentioned that he liked foreign languages as well as art and music. The senior officer told him about the courses he could do in prison and about the Chaplaincy’s guitar group. He said that they watched a television programme together and chatted about it. The man mentioned that being in prison was a “big unknown” to him but he also said how friendly the staff had been towards him and how different he found it compared to how prison was portrayed on television. However, at the next case review on 29 March, the man said that: “... it would be better for everyone if he wasn’t here and they would soon get over him.”
33. An officer made an entry in the man’s ACCT form in the late morning of 31 March after they had spoken. The man had said in their conversation that he was unsure whether he had any future as he thought his family “would be better off without him”.
34. A Specialist Psychiatric Registrar with County Durham and Darlington Community Health Services was interviewed by my investigators. Her duties

include weekly visits to HMP Durham for consultations with prisoners on her psychiatric case load. The frequency of consultations with individual prisoners is dictated by their needs. She first met the man on 31 March. As it was their first consultation it would have taken around one hour. She said that he spoke about a good upbringing but also said he had been an anxious child lacking in confidence and that he was bullied at school. He spoke about feeling different to other people and said that he had felt that way since primary school.

35. The man told the Specialist Psychiatric Registrar he started harming himself towards the end of his time in secondary school and also said that he had always wanted to kill himself. Her note of the consultation included that after obtaining many GCSE passes, the man dropped out of college due to bullying. He obtained a job with a well known optical store but stopped going to work as he could not cope with the pressure. She described the man as dishevelled, flat in mood and making little eye contact. He became tearful when he spoke about his alleged offence. At the end of the consultation the Specialist Psychiatric Registrar decided that she needed to see the man again in view of his long standing chronic low mood and poor problem solving skills, both of which made him more vulnerable to self-harm.
36. A senior officer spent the night of 1 into 2 April supervising the man. The senior officer told my investigator that the man was very chatty. He spoke about his girlfriend, his hobbies and his taste in music. He also spoke a little about his alleged offence and seemed full of guilt and remorse for what had happened. The senior officer said the man was frightened about being in prison, but at that early stage his principal emotion was one of numbness.
37. The man had a further review with the CPN on 2 April. Her note of the consultation included that:

“... [the man] felt that it was his right to take his own life and this has been a view that he has held for many years ... He could not see any future and even when released his life would be spoilt anyway, having a criminal record. His girlfriend and parents are sticking by him. He feels that if he were dead they could grieve [and] then get on with their [lives] ...”
38. The CPN did not make an entry in the man's ACCT form following their consultation and my investigator asked her about this. She said that she would ordinarily make an entry in an ACCT form but accepted that she did not do so on this occasion. She thought that the most likely explanation was that she had been so busy that day that she had forgotten.
39. The man had another ACCT case review on 3 April. A Registered Mental Nurse (RMN) was one of the panel review members. Having reviewed the case papers, the RMN told my investigators that he did have some recollection of that review. He recalled the man telling the panel that the intrusion of being maintained under constant supervision was making him quite self conscious. The RMN said that, ideally, prisoners should be maintained on constant supervision for as brief a period as possible. In terms of the general practice regarding clinical input on ACCT case reviews, he said that that was dependent

on need. In the case of prisoners in contact with the mental health team there should be contact between the ACCT case manager and the team. The record of the case review that day included that the man seemed a little brighter in mood. The panel decided that supervision of the man could be reduced from constant to five observations per hour. (Durham's suicide prevention co-ordinator was another of the panel members).

40. The man spent twenty minutes talking with a Listener on the morning of 6 April. After seeing the Listener he told an officer that he was feeling "okay".
41. On 7 April, a colleague of the Specialist Psychiatric Registrar was scheduled to review the man on her behalf. Unfortunately, the colleague was not able to see the man due to time constraints. In a letter to the prison's Medical Officer (the lead doctor), the colleague explained that he had spoken with two of Durham's nurses who informed him that the man was "picking up slowly". They told him that there had been no episodes of self-harm, nor any threats of self-harm. He added that the Specialist Psychiatric Registrar would be reviewing the man in a week's time.
42. At an ACCT case review the following day, the man told the panel that he now felt that he had more to live for. He explained that he was receiving support from his family and his partner and that was preventing him from "doing something serious". Two of the panel members were mental health nurses. After discussion, the panel decided that his observations could be reduced to two per hour.
43. The man was still in healthcare on 14 April, when he attended a further ACCT case review. All the issues on the caremap had been addressed and the notes made about the review included that he was presenting as much brighter and much improved. The note went on to say that he was more settled and was mixing well with others and that all those at the review were in agreement that the ACCT form should be closed. A post closure review was scheduled for 21 April. (The entries in the ACCT form show that on most days while the form was open he had taken part in some form of out of cell activity such as going to exercise or education. Most commonly, he simply spent time on association with other prisoners.)
44. Later on 14 April the man had a further consultation with the Specialist Psychiatric Registrar. She told my investigators that, as it was a review appointment, it would have been a briefer consultation than their first. It would have lasted around 15 to 20 minutes. She said that the man had improved from the time of their first meeting. This time he made more eye contact and was more reactive in mood. Although the man denied any current plans of self-harm, he said that he continued to have such thoughts and they were always in his head. The Specialist Psychiatric Registrar's recommendation was for him to continue with the anti depressant medication Citalopram which he had just started taking.
45. For the week following the closure of the ACCT form the comparatively brief records made in that period suggest that the man was continuing to settle quite

well. At a routine post closure ACCT review on 21 April he was noted to have said that he was feeling “really good” and not feeling at risk of self-harm or suicide at that time. An entry in his clinical records that same day, however, shows that he had asked to speak to a Listener although he then declined the opportunity when the Listener went to his cell.

46. The man had a discussion on 22 April with one of Durham’s doctors who noted:

“Interviewed in cell ... Good rapport, rational, articulate. Requesting a transfer to normal wing as he needs to ‘get on with prison’. Also on a normal wing he may be allowed access to a guitar as music is very important to him. Denies any current suicidal thoughts or self harm but I am not entirely convinced and will discuss with colleagues before discharging him.”

47. The following day, the doctor authorised the man’s discharge from healthcare noting that he had no current medical problems but that there should be a follow-up check by the mental health nurse.

48. Durham’s suicide prevention co-ordinator told my investigator that, by the time the man had returned to E wing on 23 April, there was a marked improvement in his mood and demeanour. He had acquired some photographs to mount on the pin board in his cell and invited him into the cell to look at them. These included photographs of his partner and of his pets. He appeared more relaxed and seemed to believe that he had a chance of getting bail. He also thought that he might get a lesser sentence than he had previously believed and spoke about how he would rebuild his life after release. The suicide prevention co-ordinator told my investigator that he saw the man numerous times ‘in passing’ at around this time and he appeared much less agitated and much less worried about prison life. He said the man did mix with other prisoners, but tended to associate more with the older prisoners and preferred to meet with smaller groups.

49. The man had a mental health review on 27 April with the CPN who noted:

“[The man] stated that moving to the main jail has helped a little. He feels a little less stressed ... although not actively suicidal, it is still an option. He has used the Listeners on a couple of occasions. Although admits to finding it difficult to talk generally to people, found it had helped a little ...”

50. On 3 May, during a check of the man’s cell during the lunch period, staff found a home-made bladed weapon that he said he had made over a week before. The suicide prevention co-ordinator told my investigator that, when he found out about this incident, he went to speak with the man and asked him if he had made the weapon for protection. His reply was that he had made the weapon in order to harm himself if he happened to feel low in mood.

51. A landing officer based on E wing told my investigators that he had been on annual leave when the man was transferred to E wing. He returned to work on 3 May and met him for the first time that day. When the officer unlocked the man’s cell at about 4.00pm, so he could collect his evening meal, he found him

lying under his bed in a distressed state. The officer said that he was weeping, although not crying out loud. He asked the man to come out and to sit on his bed, which he did straight away. The officer knew that the man had had a visit that afternoon and asked him if it was that which had upset him. The man denied that it was anything to do with the visit but would not say what it was that was upsetting him.

52. The officer estimated that he spent around ten minutes with the man and was joined by two of his colleagues. The staff discussed whether the ACCT form should be reopened. The man did not want the ACCT form reopened but the staff considered that it was appropriate to do so in view of his demeanour. Staff tried to persuade him to collect a meal but he declined to do so. Once the evening meal had been served, the landing officer checked with the safer custody team whether he needed to open a new ACCT form or whether the previous one could be reopened. He was advised that he could reopen the earlier ACCT and that is what he did. By the time the officer had done so, it was around 5.00pm and that was the end of his shift. He could not recall having any further personal contact with the man.
53. The case manager for an ACCT case review with the man on 4 May recorded that, while the man denied having thoughts of suicide or self harm, he was reluctant to engage in conversation and would not make eye contact. She noted the man saying that he had made the bladed weapon to use on himself. She told my investigators that she thought the ACCT form should remain open and she told him of that decision. She could not recall his reaction.
54. A number of entries in the man's ACCT form on 6 and 7 May indicate that he was feeling a lot better compared to how he had been on the day the form was reopened. He said that he had no concerns when told on 7 May that he would be moving wings that day. (Prisoners remain on E wing only while they receive their induction. They then move to the residential wings while the freed-up cells on E wing are taken by new arrivals.)
55. (The role of a moves officer entails finding accommodation for newly arrived prisoners and to move other prisoners to allow facilitate the accommodation of the new prisoners.) The moves officer for 7 May told my investigators that he would have moved around 20 prisoners off E wing that day. He could not specifically recall moving the man, but assumed that he must have done. He thought that the reason the man went to D wing, the Integrated Drug Treatment Programme (IDTS) wing, was because he was not suitable to share a cell and D wing would have been the only wing with a vacant single occupancy cell. (The man was still deemed to be high risk for cell sharing purposes.)
56. Durham's suicide prevention co-ordinator told my investigator that he did not see the man after his move to D wing, but his view was that he would not have coped well on that wing. His personality would probably have led to him being a target for bullies who would have hoped to take any prescribed medication from him. He said that the man was not the type of person who would complain about being bullied as he would not want to bother staff about such matters.

57. An officer on D wing told my investigator that she had worked on all the wings in Durham and for the past five years had worked on D wing. She said that although D wing was very busy and very noisy, she had not observed any incidents of bullying. The officer thought that she first met the man on 11 May. At breakfast time that day she had gone to his cell to check that he was alright. He told her that he was worried because a very expensive item had been mistakenly recorded on a catalogue order form. She went to check what had happened and then returned to his cell to tell him not to worry as the prison realised it was a mistake.
58. Later that day the D wing officer had a longer conversation with the man. She went into his cell and he spoke about his concerns over his court case. She told him not to worry as hopefully the court would look leniently upon the mitigating factors. There was also a lighter side to their conversation when he spoke about his girlfriend and about his pets. The officer told my investigator that she saw a photograph on his pin-board and she asked him if it was a sheep. The man laughed and told her that it was an albino hedgehog. She thought that she spent around 20 minutes talking with him.
59. The man's next consultation with the Specialist Psychiatric Registrar was on 12 May. She told my investigators that before seeing him she checked his clinical records and those indicated that he had continued to improve. When they met, he told her that he was generally okay but was struggling during association periods as the other prisoners on the wing were drug users. He said that he had asked for a transfer to a different wing. He also said that his ACCT form had been reopened when staff found a blade in his cell. He also told her that he had used the blade to cut his wrist although staff were not aware of that. She asked him whether he had done anything else to harm himself, and he said that he had also tried to use a sheet as a ligature but staff were again unaware of that.
60. Following the appointment, the Specialist Psychiatric Registrar dictated a record of the consultation which was later typed and inserted into the man's clinical records. Her record included that:
- "[The man] was taking Citalopram [an anti-depressant] when I last reviewed him, although has stopped taking it ...
- "[He] appeared less withdrawn than when I initially assessed him. He continues to present however with some evidence of low mood and suicidal ideation on a background of chronic dysthymia (a depressive illness characterised by chronic low mood) ...
- "... I have discussed [the man's] case with [an RMN] who will enquire as to whether he could be transferred ... to another wing. He will also explore the possibility of [him] sharing a cell and being able to attend education or the music group.

“... [the RMN] will inform the Safer Custody Team of [the man’s] recent attempt at ligaturing and his ACCT observations should be increased as necessary.

“... I have recommended that [he] is prescribed Zopiclone [for sedation at night] for one week. [He] did not want to take any anti-depressant medication at present but I will review the situation when I review him again in two weeks time.”

61. Following the consultation, the Specialist Psychiatric Registrar spoke to the RMN about what the man had said about his attempt to use a bed sheet as a ligature. The RMN gave her the man’s ACCT form and asked her to make an entry about the comment. Her entry, which filled almost a complete side of paper, included:

“... admitted that he had attempted to use sheet as ligature in the last 2 weeks. Continued to state he was ok and denied planning to self harm although contradicted himself later on in interview by stating he always wanted to kill himself.”

62. The RMN told my investigators that following a consultation with a prisoner by a visiting psychiatrist, it is good practice for the psychiatrist to report back to the mental health team. The RMN said that the Specialist Psychiatric Registrar did this on 12 May when she spoke to him about the man. She told him that the man’s mood had improved but he had also told her about making a ligature. The RMN ensured that the Specialist Psychiatric Registrar made an entry in the ACCT form. He said that he did not speak to the safer custody team about what she had revealed as no one from the team was available. He said, however, that he went to D wing and handed the ACCT form to an officer and informed her about what the Specialist Psychiatric Registrar had written. He asked the officer to pass on the information to one of the wing managers.
63. The officer told my investigator that she had no recollection of the RMN speaking to her about the Specialist Psychiatric Registrar’s entry in the ACCT form and asking her to pass on that information to the senior officer on duty. Nor could she recall having seen the Specialist Psychiatric Registrar’s entry before the interview with my investigator. She assumed, however, that she must have done as she made the very next entry in the ACCT form and her practice when making entries was to read the preceding one. The officer made her entry in the ACCT form at 4.40pm. She said that at that time of day all the cells would be locked so she had spoken to the man through the door hatch. Had it not been a ‘lock-up’ period she would have gone into the cell to ask him if it were true that he had been making ligatures. But that was not a question she would ask through a locked door as other prisoners would be able to hear the remark from their cells. She added that the Specialist Psychiatric Registrar’s entry about the ligature did not accord with her own assessment of the man. From the discussion she had had with him earlier that day she believed that thoughts of his partner and his parents would prevent him from doing anything. Her shift ended at 5.00pm and that was the last time she saw the man.

64. The wing manager told my investigator that the officer did not speak to him about the entry that the Specialist Psychiatric Registrar made in the man's ACCT form. Nor could he recall having seen the comment before my investigator showed it to him.
65. On the morning of 13 May, the CPN made the following entry in the man's clinical records:
- "Seen by CPN for review. [The man] presented as low in mood. He denied feeling suicidal, but admitted to having self harmed, although staff were not aware of this, did find a razor blade in his cell ... We looked at the consequences of this action, such as possibly being declined a guitar in his cell. [The man] could not see the problem and stated he would not use the strings to self harm. I contacted ... Chaplaincy who [are] unsure whether security would allow the guitar at the present time, but he was near the top of the list for lessons. As he finds music therapeutic, I suggested that he buys a CD player and ... see if the library have any CDs for loan. [The man] was fairly negative towards this and other suggestions. I arranged for him to go to the library this [morning]. We looked at what else could help. This included the gym and moving wings. I have encouraged him to put in [applications] for gym induction and work, but he did not appear bothered ..."
66. The CPN made further entries elsewhere following her consultation with the man. In his ACCT form she made an entry in which she referred to his low mood. She also noted his denial of current thoughts of self-harm or suicide as well as his plans to engage in more activities. In the wing observation book, the CPN referred to the man's visit to the library. She also wrote that he was interested in buying a CD player as he: "finds music therapeutic". (The CPN dated this entry 14 May; it should, however, have been dated 13 May.)
67. A senior officer on duty on D wing on 14 May told my investigators that, although she was primarily based on E wing, she also worked on other wings to cover staff shortages. This was why she was on D wing that day. She said that one of her first tasks at the start of a shift is to check the open ACCT forms and whether any case reviews are due. She saw that the man was due for a case review. She did not realise at that time that this was the same person she had met for an ACCT review ten days earlier on E wing. When the man came to the review the senior officer remembered him from their previous meeting. She said he appeared to be a lot better. He was able to hold a conversation and was making eye contact. The man denied having thoughts of suicide or self-harm. He was also making plans for the future: he had applied for work, he had asked for a guitar from the Chaplain, and he talked about visits from his family. He did not complain about feeling intimidated on D wing.
68. The senior officer said that she discussed the man with an officer also present at the review and they agreed that the ACCT should be closed. The senior officer said she had briefly reviewed the ACCT entries from the previous day and the day before. She saw the entry made by the CPN who noted that, although the man was still feeling low, he was making plans for the future and was not going to harm himself. The senior officer felt that was sufficient mental

health input for the review and that there was no need to invite someone from healthcare to join the panel. She said that, as far as she was aware, there was no set procedure at that time about having a healthcare representative on a panel that might be considering the closure of an ACCT form. (Since the man's death, local procedures have changed. Healthcare must now be involved if a panel is to consider closing an ACCT where the person has received significant healthcare input.)

69. The senior officer told my investigators that she did not see the entry in the ACCT form made by the Specialist Psychiatric Registrar on 12 May. Having read the entry during her interview, the senior officer was not certain that it would have made any difference had she seen it on 14 May. She accepted that the decision to close an ACCT should be based on more than just how the person presents on the day of the review. But she reiterated that the man's mood had improved markedly compared to how he had been ten days previously and the entries she read in the ACCT gave her no cause for concern.
70. At interview, the officer who was also at the review and who agreed about the ACCT being closed, described D wing as a very hectic and noisy wing holding a lot of young men in their early twenties to early thirties doing "a lot of running around". She said that although she had not been approached personally by prisoners complaining about being bullied, she was aware of incidents where prisoners had complained about their medication being stolen.
71. The officer confirmed that she had not met the man until the day of the ACCT review on 14 May. She said that the senior officer had had dealings with the man on E wing and she commented on how much better he now seemed. The man agreed that he was feeling much better in himself, but also said that he was bored and would like to get out of his cell a bit more. The officer had collected a labour form from him that morning, and she told him that she had dealt with that application along with his request to attend education classes. He also said that he would not mind sharing a cell at some point, but did not want to share a cell on D wing as he did not want to be involved with prisoners receiving drugs.
72. The officer said that the senior officer asked the man whether he was having any thoughts of suicide or self harm and he denied such thoughts. She told my investigators that the man engaged fully in the conversation; he was not withdrawn and he made good eye contact. Once he had left the room the senior officer said that she thought the ACCT form could be closed and asked the officer for her opinion. The officer agreed. She told my investigators that she was content that that was the correct decision based on how the man was on that day.
73. The officer also told my investigators that she thought she had attended around a dozen ACCT reviews, and on only one of them had a mental health nurse been present. Nor did she know if a telephone call was ever made to the mental health team for their views. She said that, as far as she was aware, no thought was given to asking a healthcare person to attend the man's review.

74. On the morning of 15 May, the man told an officer that he wanted to speak to a Listener. One of D wing's Listeners went to see him. The Listener told my investigators that the man told him that he would harm himself and he explained why he intended to do so⁶. He also said that he wanted to move back to healthcare and agreed that the Listener could speak to an officer on his behalf. The Listener said that he alerted the senior officer and accompanied him back to the man's cell. He remained present while the senior officer spoke with the man. However the man denied to the senior officer that he was thinking of harming himself although, according to the Listener, he did ask to move to healthcare. The senior officer told the man that he could not go to healthcare but told him that he would arrange a transfer to C wing.
75. The senior officer confirmed to my investigator that he went to speak with the man after being alerted by the Listener. The man said that he was frightened and had not been collecting his meals. He did not cite any specific incidents of bullying, however, nor did he name any individual prisoners. The senior officer told my investigator that he would arrange to transfer him to a different wing. He told him that F wing, which held full time workers, was the wing he should ultimately aim for. In the interim, the senior officer said he would move him to C wing which was a much quieter wing than D wing. He told the man that he would arrange to transfer him as soon as possible, although it would probably not happen until the coming Monday. The man said he was content to wait until then. The senior officer told my investigator that there was nothing about the man's demeanour to indicate that he was desperate to move. He could not recall either the man or the Listener mentioning a move to healthcare.
76. On the same day, the senior officer wrote on a 'cell sharing risk minimisation plan' that the man would like to share a cell provided a suitable prisoner could be identified. He also wrote that the man was: "... A nervous individual who is not engaging with the regime as he appears to be afraid."
77. The senior officer told my investigator that his practice at meal times was to stand by the servery. He said that the man's cell was near to the serving point and on 15 May he escorted him to the servery to collect a meal. The senior officer said that he was on duty throughout that weekend, and he had made a point of unlocking the man's door at most of the meal times. He thought that the only meal the man missed was on the Sunday evening when he said that he was not hungry. He said that, in addition, he arranged for the man to shower alone on the Saturday (16 May) and offered him the same option the following day. He also asked the landing officer to "keep an eye" on him.
78. In his discussion with my investigator, the senior officer acknowledged that D wing, given its purpose, could be chaotic at times and that it was not an appropriate environment for a person such as this man. Nevertheless, nothing occurred during that weekend to cause him to feel concerned for the man's safety.

⁶ Due to the principle of confidentiality under which the Listener scheme operates, the Listener could not reveal to my investigators the explanation given by the man.

79. My investigator observed the available CCTV recording taken on D wing. This covered a 24 hour period from 8.00am on 17 May to 8.00am on 18 May. During this period the man came out of his cell on four occasions. Three of these occasions were to collect his three meals of the day. The other occasion was to attend a family visit in the early afternoon. The only time that a prisoner appears to be attempting to converse with him while he was in his cell was in the middle of the afternoon. The prisoner remained at the door for almost a minute. On two occasions the prisoner can be seen crouching down and it appears that he might be trying to speak through any gap between the cell door and frame. However, the CCTV recording is silent so it remains unclear what is occurring. Around 15 minutes after this the man came out of his cell to collect his final meal of the day.
80. The man's father, grandmother and partner visited him the day before he died. His father told my Family Liaison Officer that his son could hardly talk because his mouth was so dry. He said that his son's mouth would dry when he was worried or upset. His father said that another difference that day was that, when the family were leaving, his son stared him straight in the eye and he waved. This was different to the norm as ordinarily it was difficult to catch his son's eye at the end of a visit.
81. An Operational Support Grade (OSG) staff member told my investigators that he had been responsible for patrolling D wing on the night of the man's death. At night he carries an anti-ligature knife and a cell key held in a sealed pouch. The seal must only be broken in the case of an emergency. At around 5.30am he was carrying out a cell check. When he looked into the man's cell he saw him lying face down on the floor. There was a ligature around his neck, tied to the bed frame. He said that he banged on the door and shouted to try to get a response from the man. Getting no reply, the OSG called for assistance from the Night Orderly Officer⁷ (NOO) and the first response nurse. He broke the seal of the key pouch and stood ready by the cell door. He said that the assistant NOO arrived in around 20 seconds followed by two nurses. When the assistant NOO was a few feet away the OSG unlocked the door and they went into the cell. They cut the ligature from the man's neck. As nurses were present by this time, the OSG left the cell. He confirmed that he was aware of Durham's contingency plans about entering a cell at night time. He said that he would have entered the cell before the arrival of support if it was clear that the man was hanging. However, the situation was not clear which was why he decided that he should wait for support to arrive.
82. A Registered General Nurse (RGN) was the first response nurse. She arrived at the cell just after the ligature had been cut away. She examined the man and found no signs of life. She recorded that rigor mortis was established and so resuscitation was not attempted.

⁷ The Night Orderly Officer is the person in operational charge of a prison at night time.

After the man's death

83. A hot debrief was held for the staff who responded following the discovery of the man's death. A member of the care team was present to offer her support.
84. One of Durham's Family Liaison Officers, along with a colleague, travelled to the home of the man's parents at around midday to break the news. His father was at home but his mother was at work. The staff informed the man's father of his son's death and asked him whether he wanted to contact his wife. He said that he thought it best to wait for her to finish her day's work and to come home before telling her. They asked if he had any support available to him in the meantime, and he told them that his mother-in-law lived nearby.
85. In the early afternoon the man's mother telephoned and asked if she and her husband could come into the prison. They came in that afternoon and attended an initial meeting with the prison Governor and the Family Liaison Officer. The man's mother told my investigator that her husband said at the meeting that he did not want his son to be subject to a post mortem examination. The Family Liaison Officer said that such an examination had already been carried out, although the family later discovered that the post mortem examination was not carried out until later that afternoon. The man's mother said that she and her husband asked to visit D wing. They were told that it was the association period and were asked to return after prisoners had been locked in their cells. She said that she and her husband accepted this, but said they were not offered any where to wait inside the prison so they waited in their car outside. They went back to the prison around 45 minutes later and were able to visit D wing. They were not able to visit their son's cell, however, as it had been sealed and the police had not given permission for its release. The man's parents were informed that Durham would contribute to the costs of the funeral arrangements in line with national policy. That evening, the man's parents and his partner visited the local hospital to view his body. The man's mother said that they found Durham generally unhelpful unless pushed for information.
86. My investigator asked the Family Liaison Officer about the man's mother's complaint that the family were misled about the timing of the post mortem examination. The Family Liaison Officer denied commenting on the post mortem.

Immediate review of local procedures

87. A prison governor told my investigator that, as the man's death was the fourth at Durham in a fairly brief period of time, an immediate review was carried out to consider if there were any procedures that needed to be changed. This review resulted in the issue of a notice to staff to say that, where a case review team is considering the closure of an ACCT plan, the review panel must include a member of staff who knows the prisoner well. In the case of a prisoner who has had mental health support, the panel must include an appropriate member of healthcare staff.

88. Another issue discussed by my investigator and the prison governor was how significant entries in ACCT forms, such as the Specialist Psychiatric Registrar's, become submerged within the form as further ACCT entries are added. The governor's suggested solution was the introduction of a new section in the ACCT form in which reference is made to significant entries elsewhere in the ACCT. Such references are then 'struck through' when the issue of concern is resolved leaving it easy for the reader to identify potentially unresolved issues.

Thematic review of the last three deaths at Durham

89. As I have said, the man's death was the fourth self-inflicted death in Durham within a period of just ten weeks. A common theme amongst the last three deaths was that all the prisoners had been subject to support and monitoring through the ACCT procedure up to, or close to, the time of their deaths. The Safer Custody Advisor for the North East region reviewed the three ACCT forms. His findings on reviewing the man's ACCT forms included that:
- There should have been a case review each day for the first 72 hours after the man was placed on constant observation. Reviews were not held on 30 March and 31 March.
 - The post-closure review scheduled for 21 April did not take place.
 - When the ACCT form was re-opened an assessment interview was not held.
 - Some daily entries in the second ACCT indicated good interaction between staff and the man but most entries merely recorded brief exchanges with him.
 - There was no healthcare representation at the case review on 14 May when the second ACCT was closed. Nor did the panel refer to the ACCT entry made by the Specialist Psychiatric Registrar on 12 May.
90. The Safer Custody Advisor was also critical of the level of management checks carried out on the ACCT forms for all three prisoners.

THE MAN'S JOURNAL

91. After the man's death, two documents were found in his cell. One was a goodbye letter to his family. The other was a document totalling six sides of A4 paper in which he recorded his thoughts during the final days of his life. He also noted a series of complaints about things that had happened and were continuing to happen. Problems that he listed included a cell mate who had stolen items from him; that food had been stolen from him; that when on E wing his sink had been blocked for more than two weeks; that social visits had been foreshortened; that mistakes had been made with canteen and catalogue orders; that association periods had been at irregular times; that evening meals were served at irregular times and on occasions he was overlooked for breakfast; and that he had not received prescribed sleeping tablets. He also complained about the prison failing to arrange education classes, and failing to arrange visits to the library, the church and the gym. The man's major complaint, however, was his fear of the other prisoners on D wing who he noted kept coming to his cell to make threatening demands for medication and tobacco. He wrote that he complained to an officer about being fearful of other prisoners but that the officer had told him not to worry as they were only "hollow threats".
92. The man also referred in the journal to his conversation with a senior officer on 15 May (Friday). He noted that he had previously been told that he would be transferred back to healthcare if he was "struggling", but when he asked the officer about that he was told he could not be transferred. He added, however, that the officer did say that he would hopefully be able to transfer him to a different wing on the following Monday. The end of the fourth side and the whole of the fifth side cover the events of Friday 15 May. The sixth and final side is annotated "Saturday"⁸ and includes the following commentary:
- "It's going to have to be tonight, I have no other choice ... I've had a [prisoner] banging on my door threatening me if I don't give him [tobacco]. I've already given him a pouch. Why could none of the guards see him shouting and banging on my door? He went away eventually and then came back! I was so scared I refused to go out for lunch ... this morning I actually had hope, I thought 'I can get through this.' The straw that broke the camels back was today ... having some fucking crazed smack-head demanding [and] threatening ... It's 4.00pm, he's been back again ... If I don't give him [tobacco and cigarette paper] apparently my life's gonna be made hell in here ... I can't take this anymore."
93. In accordance with standard protocols, the two documents left by the man were seized by the police investigators. From his journal, the police extracted 31 issues that they put to Durham seeking the prison's responses.

⁸ NB: The man took his life at some time between the final roll check on Sunday evening and the early morning roll check on Monday morning. This may mean that he changed his mind about taking his life on Saturday night but made no journal entries for Sunday. Otherwise, it means that he made no journal entries on Saturday and then incorrectly annotated the final page "Saturday" when in fact it should have been annotated "Sunday".

ISSUES

Reopening of the ACCT form on 3 May

94. The man's original ACCT form had been closed on 14 April when he was deemed no longer at risk. A new ACCT form was opened on 3 May when he was found underneath his bed in a distressed and tearful state. The officer who discovered him sought advice from the safer custody team and was told that, because the original ACCT form had been closed only recently, there was no need for a further initial ACCT assessment interview and no need for a new caremap. My investigator spoke with the training delivery and operational adviser for issues related to Prison Service Order (PSO) 2700 which gives instruction and guidance on the ACCT process. My investigator was advised that although PSO 2700 is silent on the matter, staff at Durham acted appropriately in deciding that there was no need in this man's case for a further ACCT assessment interview and new caremap.

I recommend that the Prison Service consider revising the instructions given in PSO 2700 to include explicit mention about the action to be taken when an ACCT plan is reopened.

Communication following the man's consultation with the Specialist Psychiatric Registrar on 12 May

95. During his consultation with the Specialist Psychiatric Registrar on 12 May, the man disclosed that at some stage in the previous two weeks he had made a ligature from a bed sheet and tried to use it on himself. Following the consultation she spoke to an RMN. He advised her to make a relevant entry in the man's ACCT form (which she did), and he also told her that he would pass the information on to the safer custody team.
96. However, the RMN's evidence is that there were no members of the safer custody team available that afternoon for him to pass on the information. Instead, he spoke to one of D wing's landing officers when he handed her the ACCT form. The RMN said that the officer agreed to pass on the information to the senior officer on duty.
97. The officer could not recall the RMN telling her about the Specialist Psychiatric Registrar's entry in the ACCT form, nor could she recall passing the information on to the senior officer on duty. (The senior officer confirmed that the officer did not speak to him about the man.) It seems clear to me, therefore, that the officer did not alert the senior officer on duty to the Specialist Psychiatric Registrar's entry: both of the discipline officers are in agreement on that point. What is unclear, however, is the content of any conversation between the RMN and the officer. Their accounts are at variance with one another and it is not possible for me to conclude which of the two is the correct version.
98. Interestingly, however, it was the same officer who made the next entry in the ACCT form immediately following the Specialist Psychiatric Registrar's entry. She told my investigator that her practice was to read the previous ACCT entry

when making an entry of her own. That said, she had no recollection of seeing the Specialist Psychiatric Registrar's entry before being shown it by my investigator.

99. I further discuss the Specialist Psychiatric Registrar's entry in the ACCT plan in the following section.

Closure of the ACCT form on 14 May

100. There were just two members of staff at the ACCT review on 14 May, neither of whom knew the man well. This is despite the fact that a case review team should be comprised of a minimum of three staff. The case manager was also the case manager at the man's previous review on E wing on 4 May. However, it seems that her attendance at the 14 May review was more coincidental than planned. The other panel member had not met him before. The case manager told my investigators that she did not read the man's ACCT form in any depth. She said that she read the CPN's entry from the previous day, but did not read back to 12 May and so did not see the Specialist Psychiatric Registrar's entry. Having been asked by my investigators to read the entry, the case manager was not certain that it would have made any difference to her thinking had she seen the entry at the time. She said that the man's mood had improved markedly compared to how it had been at the previous ACCT review a week earlier. This day he gave her no cause for concern.
101. The case manager said she had not thought it necessary to invite a healthcare representative to the review given the meeting the day before with the CPN.
102. The other panel member gave similar evidence about the man's presentation that day. She confirmed that as with the case manager she had not read the Specialist Psychiatric Registrar's entry either.
103. It is of concern that two members of staff, neither of whom knew the man very well agreed to close the ACCT without familiarising themselves with the daily entries made since the previous case review.

The Governor should remind staff about the importance of familiarising themselves with the daily entries made in ACCT plans to assist their decision making at case reviews.

104. Following the man's death the Governor issued a notice to staff about the structure of a review panel that might consider closure of an ACCT. In this man's case, that would have meant attendance of a member of the safer custody team, a member of staff who knew the man well, a member of healthcare staff and perhaps an additional attendee, such as a member of the chaplaincy team. There is no doubt that a review panel strengthened in both size and experience in this way is likely to make more reliable decisions on whether or not to close an ACCT. I am pleased that Durham has acted so promptly in revising its local procedures on the make up of ACCT review panels.

105. It does not follow that a strengthened panel would necessarily have kept the man's ACCT open. Nor does it follow that the decision made by the case manager and the other panel member to close the ACCT was necessarily wrong. However, the review did seem to focus on how the man was on that particular day rather than how he had been managing in general since the last review. There were several aspects connected with the man's circumstances to suggest that it might have been prudent to have kept the ACCT form open. First, there are the issues very specific to his immediate circumstances: a young man who had no previous experience of the criminal justice system and was in prison for the first time, and who was charged with a very serious offence. In addition, he was a man who, as the Specialist Psychiatric Registrar explained, suffered from chronic dysthymia (chronic low mood). He told her that for a long time he had wanted to kill himself (and he had made similar remarks to community mental health staff prior to his apparent index offence). This aspect of his personality made him an unusually difficult person to keep safe.
106. However, PSO 2700 does contain specific advice on dealing with prisoners who present a chronic risk of suicide. It highlights two particular groups who can be said to be at chronic risk. One group are those who experience short-term suicidal crises repeatedly. The PSO advises that opening and closing ACCT plans many times in one period of custody, with no supervision or support in between times, is not safe. The PSO explains that such individuals need a long-term care plan, ideally one that provides some continuity of care:
- "They may have an ACCT plan [kept] open long-term over many months. During periods when the risk of suicide is considered to be very low ... the ACCT plan merely requires that a member of staff interacts with them once a day and they have reviews once a month. But when (by means of the daily interaction) staff identify that risk is increasing ... an assessment interview and case review is immediately held and additional support put in place.
- "The ... ACCT plan is closed every time the immediate crisis is over ... However, the ACCT plan is filed on the wing and one member of staff is tasked with interacting with the prisoner daily and making a note in the wing record. All staff are made aware of the signs that mean that this particular prisoner is becoming more distressed ... When risk is seen to be rising, an ACCT is opened and an assessment interview and case review carried out ..."
107. It is not possible for me to say whether such arrangements would have been successful in keeping this man safe. But it might have been a more prudent approach especially given that these were still early days for him and he was still waiting for his case to come to court.

The Governor should ensure that the safer custody team are reminded of the advice in PSO 2700 on dealing with those at chronic risk of suicide so that they can provide appropriate advice to wing staff on managing such prisoners.

The man's time on D wing

108. The man came to D wing through a slightly circuitous route. On his initial arrival in Durham he went to E wing for induction. However, due to concerns about his risk of self-harm or suicide, he was moved to healthcare. He remained in healthcare for a month. By the end of that time he was much more settled and his risk of self-harm or suicide was believed to have diminished. As a result, he was transferred back to E wing in order to complete his induction. Once induction was over, he needed to be allocated to one of Durham's residential wings as is the case for all prisoners. At this time he was considered high risk for cell-sharing purposes. This assessment was based on his alleged index offence and suspected mental health issues. It meant that he had to be located in a single cell. There is no information on record to explain why he was moved to D wing. However, the likely explanation is that, when he was transferred from E wing on 7 May, the only single cell available in Durham was on D wing. There was no particular reason at that time to think that he should not go to D wing, and therefore this move was reasonable.
109. D wing at Durham is primarily used for prisoners being maintained on the IDTS (Integrated Drug Treatment System) programme. All of the evidence points to the man being a timid and insular person, and that he tended to avoid crowds and avoided confrontation. Local information gathered within Durham about reported incidents of bullying shows that the number of incidents on D wing during the first half of 2009 was largely the same as on Durham's other main residential wings. However, most staff interviewed by my investigators agreed that D wing was a busy and lively wing, and that that it would have been an unsuitable environment for someone like him.
110. Indeed it is clear from his journal that the man found his time on the wing very difficult. This is hardly surprising given his personality and the nature of D wing. He wrote that other prisoners on the wing demanded from him drugs and tobacco. He wrote that he was scared to come out of his cell, and that resulted in him not collecting some of his meals. He noted in his journal that it should have been obvious to staff when one particular prisoner was shouting and banging on his door. He also made two references in his journal about apparently reporting problems to staff. In the first entry he wrote "I've mentioned the bullying, and put in a [complaint form] yesterday". In the second entry he wrote that when an officer asked him why he had not come out of his cell to collect his lunch he replied that he was too scared to do so. He noted that the officer's response was to say that they were "only hollow threats".
111. Unfortunately, little of what the man wrote in his journal can be corroborated as he largely kept matters to himself. Moreover, despite his reference to having submitted a written complaint about bullying, Durham has not been able to locate this document. Nor is there any other record that he complained formally about being bullied. The one established occasion when he did speak to a member of staff was on Friday 15 May: he spoke to a Listener who in turn called the senior officer on duty. The man told the senior officer that he was fearful of the other prisoners on the wing. The senior officer told him that he would arrange to transfer him to a wing to which he would be more suited. He

also advised him though that the transfer would probably not happen until some three days later, on the following Monday. The senior officer told my investigator that the man seemed accepting of that timescale. The senior officer had no reason to suspect that the situation might have been more pressing, and I conclude that his proposed plan for dealing with the man was reasonable.

112. From an entry that the man made in his journal it seems that he was under the impression based on a conversation with Durham's suicide prevention co-ordinator that he might have been entitled to a transfer back to the healthcare unit. His journal also indicates that he asked the senior officer on 15 May about moving to healthcare, which accords with the evidence given by the Listener. However, such a transfer would only occur in the case of clinical need and there is no evidence to suggest that his clinical needs warranted healthcare admission at that time.
113. Another of the man's journal entries was about cell sharing. The entry indicates a degree of despair that he might have to share a cell. However, the case manager, the other panel member and the senior officer were all under the impression from their conversations with him on 14 and 15 May that sharing a cell would be a positive move for him, although not while he was on D wing. In her response to the draft report, the man's mother wrote that her son would not have truly wished to share a cell but would have complied with whatever was asked of him by staff.

Durham's non-collusive (integrated) regime

114. Following an inspection of Durham in September 2006, Her Majesty's Chief Inspector of Prisons commented on the percentage of prisoners who reported feeling unsafe at that time: 24 per cent said they felt unsafe at the time of the inspection and 43 per cent said that they had felt unsafe in Durham at some time. The Chief Inspector referred to Durham's non-collusive (or integrated) regime and recommended that consideration be given to options for the support of vulnerable prisoners.
115. Many prisons locate their vulnerable prisoners on dedicated units. My investigator spoke with Durham's acting Governor about the option of setting up such a regime at Durham. The acting Governor pointed out that there are significant implications in running such units, however, as they require separate regimes, separate visiting arrangements, separate arrangements for education and so on. Moreover, the sad reality is that prisoner on prisoner bullying occurs even within vulnerable prisoner units. It is also important to note that the man may not have been located on a vulnerable prisoner wing even if there had been such a facility at Durham. Prisoners are usually located on vulnerable prisoner wings due to the nature of their offence making them vulnerable to violence or threats from other prisoners. This man's alleged offence did not fall into this category.
116. A minority of prisons, such as Durham, operate an integrated regime with no separation of potentially vulnerable prisoners. The acting Governor

emphasised that Durham's stated approach is to manage such a regime by dealing robustly with bullying and violence. I was pleased to learn that the Chief Inspector's very latest inspection of Durham has shown a reduction in the percentage of prisoners who reported feeling unsafe. The scores now show that Durham is performing better on this measure than the average for comparable establishments. I welcome this improvement since the previous inspection in 2006.

Should staff have recognised the man's ongoing risk?

117. The evidence from both discipline officers and clinical staff was that the man's mood improved in the weeks following his first reception into Durham. That is hardly surprising given the extremely low point he would have been at in the first few days after his arrest and remand into prison: it should be remembered that he had no previous criminal convictions and was totally unused to a custodial environment.
118. We know from the man's journal that he was growing desperate during his final days on D wing. Despite the journal entries staff did not recognise how he was feeling and of course we cannot know how clearly he communicated any of his fears with staff. Instead, the senior officer had every reason to believe that the man might in fact have been growing more optimistic, not less so, given the promise of an imminent transfer to a different wing. He took his life only hours before he would have been transferred and at a time when he had a reason to start feeling a little more optimistic than he had been for the past several days.

Concerns raised by the man's family and partner

119. The man's mother raised many issues of concern with my Family Liaison Officer. Some of these were concerns raised or shared by other family members and/or by the man's partner. These included matters both before and after her son's death. Her main concerns before her son's death largely reflected the matters he itemised in his journal. The most significant of these were probably the location of her son on D wing linked with the fact that Durham does not have a vulnerable prisoners' wing. His mother was also concerned about the management of the ACCT process including that there were only two members of staff at the panel that closed the ACCT on the second and final occasion. I have dealt with these main issues within this report. Other issues have been dealt with by letter directly with the man's mother.
120. As indicated, the man's mother was also concerned about matters following her son's death, including the way the prison dealt with the family. This included the family's claim that they were misled about the time of the post mortem examination. His mother also objected to certain comments made by the prison's family liaison officer including being told by him that he "understood how she was feeling". She responded to the remark by telling him that he had "no idea" how she was feeling. On this point, the advice contained in Prison Service Order (PSO) 2710 about breaking the news of a death in custody to a

family member explicitly warns staff not to use the phrase “I know how you feel” for the very reason the man’s mother has raised.

121. It is not possible for me to conclude with certainty what precisely was said at this initial meeting, although there is no question that it has caused great and continued upset to the man’s mother. The Family Liaison Officer role is an extremely difficult one and the first meeting with a bereaved family will usually be crucial in establishing a relationship with the family. PSO 2710 contains many pointers on what prison staff should or should not do. As I have mentioned, one is to avoid telling the family that “you know how they feel”. The PSO also advises FLOs that they must be prepared to face “raw emotion” and advises them not to “fill silences”.

I recommend that the Governor should ask his Family Liaison team to review on a regular basis the guidance contained in PSO 2710 about dealing with bereaved families.

The man’s cell-sharing risk assessment

122. When the man arrived in Durham the reception officer assessed him as being medium risk for cell-sharing purposes. However, the healthcare worker and locating officer assessed him as being low risk and therefore suitable to share a cell with another prisoner. I am rather surprised at that assessment. It was known that he been charged with murder and at that stage Durham knew nothing else of his character and personality. Based on the information held on that first day I consider that he should have been deemed as medium or high risk until more information was known. The cell-sharing risk assessment process has now changed so I make no further comment and make no recommendation.

CONCLUSION

123. The man was an unusual prisoner in several respects. In the first instance, he was a young man from a stable family background who had not previously been in trouble with the law. He was then arrested and remanded into Durham charged with murder. Those two factors, his arrival into prison for the first time and charged with a very serious offence, immediately meant that he was at high risk of self-harm or suicide.
124. The other aspect of the man's personality that made him different was his apparent predisposed attitude towards suicide. Although he reported having had a happy childhood, he informed psychiatric workers that from his early teenage years he had had constant feelings of not wanting to exist. He described having feelings of being different to others and of not being able to "fit in". He also said that for him, suicide had always been an option.
125. It is abundantly clear that the man found prison life very difficult. He had described being bullied at school and being bullied at work, so it is hardly surprising that he seems to have become a potential target for bullying within a prison setting.
126. The man would most likely have had an easier time had he been located on a wing other than D wing. It could also be argued that the second ACCT form was closed prematurely. However, given the context of a busy local prison and the limited time and opportunity available to staff in getting to know him, it is open to question how much more they could reasonably have done to prevent him acting as he did.

RECOMMENDATIONS

The following recommendations were made in the draft report. The Service responses are contained in italics below each recommendation:

1. I recommend that the Prison Service consider revising the instructions given in PSO 2700 to include explicit mention about the action to be taken when an ACCT plan is reopened.

Prison Service response: Recommendation accepted. The management of prisoners identified as being at-risk of suicide/self/harm and thereby subject to ACCT procedures is set out in current instructions. The management of an at-risk prisoner falls to the Case Manager and the Review Team throughout the process, including closure and post closure reviews. The ACCT Plan can only be closed once all the CAREMAP actions have been completed and the Case Review Team judges that it is safe to do so, i.e. that the problems that caused the ACCT Plan to be opened have been resolved or reduced and the prisoner is able to cope with any remaining difficulties. If, at this time it is felt that there is either a continuing or new risk to the individual the Case Manager can either re-open, or open a new ACCT plan and based on the risks presented determine the action to be taken to keep the prisoner safe. Target for completion: Completed and ongoing.

2. The Governor should remind staff about the importance of familiarising themselves with the daily entries made in ACCT plans to assist their decision making at case reviews.

Prison Service response: Recommendation accepted. The Safer Custody team and other relevant staff have been made fully aware of the need to comply with the instructions given in Prison Service Order 2700 about the ACCT process. Local refresher training remains ongoing in Foundation and, Case Manager procedures ensuring compliance to the PSO. Target date for completion: February 2010

Progress: ACCT refresher training given to all Senior Officers commencing from 19 May 2009 and completed by 30 June 2009. Discussed at ACCT Assessors bi-monthly meetings. On going training for foundation.

Reviewed August 2011: ACCT training is identified at all close down days and, as part of the monthly training programme.

3. The Governor should ensure that the safer custody team are reminded of the advice in PSO 2700 on dealing with those at chronic risk of suicide so that they can provide appropriate advice to wing staff on managing such prisoners.

Prison Service response: Recommendation accepted. The Safer Custody team and other relevant staff have been made fully aware of the advice in PSO 2700 on dealing with those at chronic risk of suicide so that they can provide appropriate advice to wing staff on managing such prisoners. Target date for completion: February 2010

Progress: New Safer Custody Manager appointed in November 2009 and attends Residential morning meetings on a daily basis. Also carries out daily and weekly checks of ACCT documents and feeds back to wing managers.

New Safer Custody Manager appointed November 2010 and has continued to provide support in this area.

4. I recommend that the Governor should ask his Family Liaison team to review on a regular basis the guidance contained in PSO 2710 about dealing with bereaved families.

Prison Service response: Recommendation accepted. Guidance contained in PSO 2710 will be reviewed by the Family Liaison and Safer Custody Teams to ensure the appropriate care is maintained when dealing with bereaved families. Target date for completion: March 2010.

Progress: Both FLO's aware of contents of PSO 2710.

Two further FLO's trained in March 2011.