

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr John Collins a prisoner at HMP Durham on 27 October 2016

**A report by the Prisons and Probation Ombudsman  
Nigel Newcomen CBE**

## Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

## Our Values

We are:

**Impartial:** *we do not take sides*

**Respectful:** *we are considerate and courteous*

**Inclusive:** *we value diversity*

**Dedicated:** *we are determined and focused*

**Fair:** *we are honest and act with integrity*



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr John Collins was found hanged in his cell at HMP Durham on 27 October 2016. He was 29 years old. I offer my condolences to Mr Collins' family and friends.

Mr Collins had a diagnosis of personality disorder, and a long history of severe alcohol abuse and illicit drug use. He had served several previous custodial sentences. While the investigation found some deficiencies in the operation of suicide and self-harm prevention procedures at the prison, I am particularly concerned that, following the assessment made by a psychiatrist, Mr Collins received no support from the mental health team. However, I do not consider that staff at Durham could have predicted that Mr Collins intended to take his own life when he did.

Although Mr Collins said he was in debt and being bullied, he would not provide further details and we can find no evidence to support this claim although illicit drugs are clearly a problem at the prison. I am also concerned that the investigation found deficiencies in Durham's emergency response.

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

**Nigel Newcomen CBE**  
**Prisons and Probation Ombudsman**

**July 2017**

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# Summary

## Events

1. Mr John Collins had been diagnosed with a personality disorder. He also had a long history of severe alcohol abuse and illicit drug use. Mr Collins had served previous custodial sentences, the last of which ended in September 2013.
2. On 19 September 2016, Mr Collins was remanded into custody at HMP Durham and charged with threats to kill and possession of an explosive. He was due to appear in court on 20 December.
3. On 12 October, Mr Collins self-harmed by superficially cutting his wrist. Staff monitored Mr Collins under Prison Service suicide and self-harm prevention procedures (known as ACCT) until 21 October.
4. On 27 October, a prisoner found Mr Collins hanged in his cell and raised the alarm. Staff responded immediately and began resuscitation. An emergency code was called at 11.13am and an emergency ambulance was called at 11.17am. Paramedics arrived at 11.25am and pronounced Mr Collins dead at 11.39am.

## Findings

### Management of risk of suicide and self harm

5. We found that ACCT procedures at Durham were not conducted in line with mandatory national instructions. The first case review was not conducted within 24 hours of the ACCT being opened, one ACCT review was not multidisciplinary and the post-closure review was set for eight days after the ACCT was closed instead of seven.

### Mental health care

6. Mr Collins had been diagnosed with a personality disorder. On 14 October, he was assessed by the visiting psychiatrist who confirmed the diagnosis of personality disorder. The psychiatrist was unable to prescribe anti-psychotic medication because Mr Collins had alcoholic liver disease, but agreed a care plan which included ongoing support from the mental health team. However, we found that, despite the agreed plan, Mr Collins did not see any mental health professional after this date.

### New Psychoactive Substances/Illicit Drugs

7. Mr Collins may well have abused illicit drugs, including NPS (or 'Spice'). There was no evidence to corroborate his claims that he had been bullied for drug debts. Toxicology results confirm that Mr Collins had taken illicitly obtained prescription drugs while at Durham but no evidence of NPS was found within the samples. Although there was no evidence that Mr Collins used NPS immediately before his death, the pathologist indicated that it could not be ruled out. We are concerned at the ready availability of illicit drugs at Durham.

## Emergency Response

8. We found that there was a delay of ten minutes between the time Mr Collins was found hanged and North East Ambulance Service receiving the 999 call. While this did not affect the outcome for Mr Collins, in future emergencies such a delay could be crucial.

## Recommendations

- The Governor should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines. In particular:
  - Assessing the level of risk and recording the reasons for decisions;
  - Setting and recording appropriate levels of observations which are adjusted as the perceived level of risk changes;
  - Conducting ACCT reviews as specified in the national instructions;
  - Conducting ACCT post-closure interviews as specified in the national instructions.
- The Governor should ensure there are effective supply and demand reduction strategies to help reduce the availability of illicit drugs including new psychoactive substances, and that staff are vigilant to signs of their use and know how to respond when a prisoner appears to be under the influence of such substances.
- The Head of Healthcare should ensure that the mental health team is adequately resourced to provide a level of service equivalent to that prisoners could expect to receive in the community.
- The Head of Healthcare should:
  - Ensure that all staff are aware of the requirement to complete records in an accurate and timely manner;
  - Undertake an audit of records to ensure that all interventions with prisoners are recorded fully.
- The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 *Medical Emergency Response Codes*, and their responsibilities during medical emergencies which ensures staff immediately call for an emergency ambulance when a medical emergency code is used.

## The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Durham informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
10. The investigator visited Durham on 31 October. He obtained copies of relevant extracts from Mr Collins' prison and medical records.
11. NHS England commissioned a clinical reviewer to review Mr Collins' clinical care at the prison.
12. The investigator interviewed 11 members of staff and two prisoners at Durham in November. Eight interviews were conducted jointly with the clinical reviewer.
13. We informed HM Coroner for Durham and South Darlington of the investigation. The coroner gave us the results of the post-mortem examination and toxicology results and we have sent the coroner a copy of this report.
14. One of the Ombudsman's family liaison officers contacted Mr Collins' mother, to explain the investigation and to ask whether there were any matters she wanted the investigation to consider. Mr Collins' mother asked whether Mr Collins was being monitored because he was thought to be at risk of suicide at the time of his death, and whether he had been bullied. Mr Collins' family received a copy of the initial report. They raised a number of issues/questions that do not impact on the factual accuracy of this report, and have been addressed through separate correspondence.

## Background Information

### HMP Durham

15. HMP Durham is a local prison serving the courts of Durham, Tyneside, and Cumbria, and holds approximately 1,000 men. G4S provides primary healthcare services and Tees, Esk and Wear Valley NHS Trust provides mental health services.

### HM Inspectorate of Prisons

16. The most recent inspection of HMP Durham was conducted in October 2016. Inspectors reported that, since the previous inspection in 2013, the prison was still not safe enough and not sufficiently respectful. Inspectors found that more prisoners felt unsafe and there was clear evidence that illicit drugs were readily available in the prison. Inspectors observed both commendable interaction and care by many staff but also too much disengagement and lack of care by others. Inspectors noted that outcomes in work, learning and skills, and the prison's delivery of resettlement had deteriorated. Inspectors found the provision of health care was reasonable, with some excellent mental health interventions.

### Independent Monitoring Board

17. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its annual report to October 2016 the IMB reported that healthcare staff recruitment was a major issue for the prison. The IMB noted concerns that the prison was over-crowded and operated at all times close to its operational capacity, with cells built for single occupancy nearly all occupied by two prisoners. The IMB also reported that the number of violent incidents had increased and the lack of CCTV evidence prevented perpetrators being brought to justice.

### Previous deaths at HMP Durham

18. Mr Collins' was the fifth self-inflicted death at Durham since 2014. We are very concerned to have to raise again the need to call for an emergency ambulance immediately after an emergency code has been called.

### Assessment, Care in Custody and Teamwork (ACCT)

19. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be carried out at irregular intervals to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner. As part of the process, a caremap (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner

as he moves around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, *Management of prisons at risk of harm to self, to others and from others (Safer Custody)*.

### **New Psychoactive Substances**

20. New psychoactive substances, previously known as 'legal highs' are an increasing problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of NPS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.
21. In July 2015, we published a Learning Lessons Bulletin about the use of NPS and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of NPS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.
22. HM Prisons and Probation Service (HMPPS) now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements. Testing has begun, and HMPPS continue to analyse data about drug use in prison to ensure new versions of NPS are included in the testing process.

## Key Events

23. On 19 September 2016, Mr John Collins was remanded into custody charged with threats to kill and having an explosive (petrol-based) device. (He was due to appear at court again on 20 December 2016.) The intended victim of his threats was his mother. Mr Collins was also under a restraining order preventing contact with his biological father. He had previously served custodial sentences, the last ending in September 2013. Mr Collins had a history of severe alcohol abuse and drug abuse. He had been diagnosed with a personality disorder.
24. On 19 September, at 7.30pm, Mr Collins arrived at HMP Durham and saw a nurse. She recorded that he had a personality disorder and suffered from alcoholic liver disease. Mr Collins said he had no current thoughts of self-harm or suicide but said he had self-harmed in 2011, when he was in low mood due to alcohol misuse. He said he had abused alcohol since the age of 14 and drank nine litres of cider a day. He also said he used cannabis. She referred Mr Collins to the substance misuse team and requested his records from his doctor in the community.
25. A prison doctor also saw Mr Collins that evening. He recorded that Mr Collins had a history of mental illness, for which he had been prescribed mirtazapine (an anti-depressant) in the past. He prescribed 10mg of chlordiazepoxide (for alcohol withdrawal) and 100mg of thiamine (a vitamin supplement for alcohol withdrawal). He referred Mr Collins to be seen by the substance misuse doctor the next morning.
26. On 20 September, a substance misuse doctor saw Mr Collins, who confirmed that he drank, on average, nine litres of strong cider daily along with vodka if it was available. She noted that Mr Collins average daily consumption was between 68 and 100 units of alcohol. (The daily recommended amount for a man is 2 to 3 units.) She recorded that Mr Collins was in acute alcohol withdrawal, was physically unwell and in danger of liver failure and of fitting. Due to Mr Collins' alcoholic liver disease and the risk of Wernicke's encephalopathy (alcohol induced brain damage), she prescribed pabrinex (a high potency vitamin B and C intra-muscular injection) in addition to the prescribed thiamine and chlordiazepoxide.
27. Later that day, Durham received Mr Collins' community GP medical records, which confirmed that he was not on any prescribed any medication at the time of his remand, but that he had previously been prescribed mirtazapine (for depression) and salbutamol (for asthma). The records showed that Mr Collins had alcoholic hepatitis in 2014, several incidents of drug overdose in 2011, admission to hospital (a mental health unit) in 2011, when sectioned under the Mental Health Act and had self-harmed by cutting in 2008.
28. Records show that Mr Collins was monitored every day by the clinical substance misuse team. He was seen mostly by a healthcare support worker. At interview, she said Mr Collins had progressed well with his alcohol withdrawal and she had had no concerns. She said she recognised that Mr Collins had serious withdrawal issues as the doctor had prescribed pabrinex, which is only prescribed when someone has an acute drink problem.

29. On 26 September, a prison doctor saw Mr Collins as he complained of loss of appetite, sickness and diarrhoea. He recorded that Mr Collins was jaundiced, his abdomen was slightly distended and he had hepatomegaly (non-specific enlargement of the liver). He arranged for Mr Collins to be admitted to hospital for an immediate assessment. Mr Collins returned to prison the later the same day. The hospital discharge summary confirmed the diagnosis of alcoholic liver disease and no changes were made to Mr Collins' treatment. There was a recommendation to continue with the alcohol withdrawal medication as required.
30. On 12 October, at 2.30pm, Mr Collins made superficial cuts to his left wrist and claimed to have swallowed razor blades. A Supervising Officer (SO) opened an ACCT document and recorded that Mr Collins said he made the cuts because he felt threatened. A nurse examined Mr Collins and recorded that there was no evidence that he had swallowed razor blades but he had made superficial wounds to his arms which she cleaned and dressed. The SO completed an ACCT immediate action plan. He recorded that Mr Collins was at a raised risk of suicide and self-harm, that he occupied a double cell and was moved to a double cell on A Wing. He noted that officers should check Mr Collins every hour until the first case review was held. He referred Mr Collins to the mental health team.
31. At 5.45pm, a psychiatric nurse saw Mr Collins to review his mental health. Mr Collins said he had previously received treatment at a hospital in Sunderland for a drug-induced psychosis in 2011, and had been prescribed mirtazapine and quetiapline (an antipsychotic). He said he felt under threat on the wing because of debt for drugs and he did not feel safe. The nurse recorded that there was no evidence that Mr Collins had an acute mental illness, but there was a clear risk that he might self-harm. The nurse arranged for a further psychiatric assessment by a psychiatrist on the 14 October.
32. On 13 October, at 10.05am, an officer assessed Mr Collins as part of ACCT procedures. Mr Collins said he had self-harmed as he was in debt, could hear prisoners shouting at him and felt unsafe. He would not name those prisoners who were threatening him. Mr Collins said that he had self-harmed since the age of 14. He said that despite cutting himself he had no more thoughts of self-harm or suicide and did not want to be dead. Mr Collins said his new cell mate had been a great help, had talked to him and he now felt safe.
33. At 3.30pm, a custodial manager held the first ACCT case review with a member of the mental health team, a SO and Mr Collins present. Mr Collins said he felt paranoid as he was in debt to another prisoner but would not name him. He said he self-harmed as a 'cry for help'. He said he did not want to die and had no further thoughts of self-harm. Mr Collins was assessed as being at a low risk of suicide and self-harm. She reduced the level of observations from once hourly to three over the course of the day and three over the course of the night. She completed the ACCT caremap which contained two actions: for Mr Collins to engage with mental health and for him to consider employment.
34. On 14 October, at 10.25am, a visiting psychiatrist accompanied by a nurse, saw Mr Collins for a mental health assessment. He noted Mr Collins' past history of personality disorder, his history of deliberate self-harm, illicit substance use, alcohol dependence and the associated physical issues that this caused. He

- recorded that Mr Collins appeared to be sedated during the assessment but he became increasingly agitated when questioned further about the hospital admissions and when asked for further background information. Mr Collins was adamant that he was not suicidal and had no thoughts about self-harm and felt safe since he had moved wings.
35. The psychiatrist recorded that there was no evidence of manic depressive psychosis and he was not prepared to prescribe any medication for Mr Collins due to the ongoing risks with his alcoholic liver disease. However, she proposed that Mr Collins could engage in psychological treatment. He agreed a care plan for Mr Collins with the nurse, which included obtaining Mr Collins' community mental health records and regular mental health reviews to monitor Mr Collins' presentation. He planned to review Mr Collins again once the community records had been received, or earlier if requested by mental health nurses. Despite the agreed care plan, this was the last time Mr Collins was seen by a mental health professional.
  36. At 4.37pm, a nurse saw Mr Collins in his cell as officers were concerned he was under the influence of NPS. Mr Collins refused to be assessed by her. She recorded that Mr Collins' pupils were enlarged and his speech was slurred, both signs that Mr Collins was under the influence of an illicit substance.
  37. On 15 October, at 1.00am, while Mr Collins was asleep, he was assaulted by his cellmate, who hit him on the head with a flask while allegedly under the influence of an illicit substance. Staff escorted the cellmate to the segregation unit and the matter was referred to the police. A nurse treated Mr Collins for his injuries. She recorded that Mr Collins had a 2cm laceration to his scalp and a 1cm laceration to the corner of his right eye. The nurse cleaned and dressed both these wounds. Mr Collins also had bruising to the bridge of his nose and grazes to his forehead. She checked on Mr Collins at 2.19am and 6.02am, and no further concerns were recorded.
  38. At 2.00pm, a SO and a nurse held an ACCT case review. Mr Collins, however, refused to participate. The SO recorded that the review took place because Mr Collins had been assaulted. Mr Collins refused to come out of his cell and said he believed he had been assaulted because he was in debt. The SO and the nurse agreed that Mr Collins' risk of suicide and self-harm was low and the level of observation remained unchanged. Later that day, another prisoner moved in to share the cell with Mr Collins.
  39. On 18 October, a SO and an officer held an ACCT case review with Mr Collins. No one from healthcare was present. The SO recorded that Mr Collins said he was nervous and felt unsafe. He and the officer agreed that Mr Collins' risk of suicide and self-harm was low and the level of observation remained unchanged.
  40. On 21 October, a SO held an ACCT case review with two nurses and Mr Collins present. Mr Collins said he got on very well with the SO, felt positive and had no thoughts of self-harm or suicide. The SO and both nurses agreed that Mr Collins' risk of suicide and self-harm was low and agreed to close the ACCT. The SO updated the caremap as all the actions had been completed. They set a post-closure review for 29 October.

41. On 27 October, at 11.07am, Mr Collins' cellmate had returned onto the wing from an appointment in healthcare. An officer unlocked his cell door to let him back into the cell and locked it again behind him. He found Mr Collins hanging from toilet door in his cell by a ligature made from bedding. He banged on the cell door to summon staff for assistance.
42. Two officers responded immediately and opened the cell door. The cellmate ran out of the cell towards the wing office and the officers entered the cell. The officers cut the ligature, lowered Mr Collins to the floor and immediately began cardiopulmonary resuscitation (CPR). Neither officer had a radio.
43. The prisoner raised the alarm with the staff in the wing office and a SO immediately radioed an emergency code blue. This indicates a prisoner is unable to breathe, or having difficulty doing so. The control room log shows the code blue was called over the radio at 11.13am.
44. An operational support grade in the control room received the code blue call. She told the investigator that she wrote the time the code blue was received on the control room log and rang for an emergency ambulance immediately.
45. Three nurses responded to the code blue call. The nurses continued with the resuscitation and used an automated external defibrillator, which administers electrical shocks to restore a normal rhythm to the heart if any is found. The defibrillator found a shockable rhythm and delivered a shock after the first cycle of CPR, but thereafter no shockable rhythm, so the nurses continued with CPR.
46. North East Ambulance Service records show that the call for an emergency ambulance was received at 11.17am. Paramedics arrived at 11.28am and took over Mr Collins' care. At 11.39am, the paramedics pronounced Mr Collins dead.

### **Contact with Mr Collins' family**

47. At 3.15pm, a prison family liaison officer and a member of the prison's chaplaincy visited Mr Collins' mother at her home to break the news that Mr Collins had died. They offered their condolences and support. In line with Prison Service instructions, the prison contributed to the costs of the funeral.

### **Support for prisoners and staff**

48. The Governor held a debrief for staff involved in the emergency response, including healthcare staff, to ensure they had the opportunity to discuss any issues arising, and for managers to offer support. The staff care team also offered support.
49. The prison posted notices informing staff and prisoners of Mr Collins' death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Collins' death.

### **Post-mortem report**

50. A post-mortem examination conducted by a Home Office Forensic Pathologist confirmed that the cause of Mr Collins' death was hanging. A consultant forensic toxicologist noted that the toxicology results confirmed the presence of

citalopram and diazepam (which had not been prescribed to Mr Collins) but found no evidence of other illicit drugs or NPS. However, she commented that while there was no analytical evidence of synthetic cannabinoid use, the negative findings do not exclude the possibility that NPS may have been used.

# Findings

## Management of risk of suicide and self harm

51. Staff appropriately opened an ACCT on 12 October, at 2.30pm, after Mr Collins self-harmed. A SO completed an immediate action plan and assessed Mr Collins as being at a raised risk of suicide and self-harm and moved him to A Wing. He set the level of observations at one per hour. The ACCT assessment interview was conducted at 10.05am, on 13 October.
52. The first case review did not take place until 3.30pm on 13 October. PSI 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*, which sets out the Prison Service's framework for delivering safer custody procedures, states that the first case review must be held within 24 hours of the ACCT being opened and ideally immediately after the assessment interview. We consider that the first case review should have been conducted sometime during the morning of 13 October.
53. The ACCT review on 18 October was not multidisciplinary as no-one from healthcare was present nor had anyone provided any verbal input.
54. This ACCT was closed on 21 October, with a post-closure interview scheduled for 29 October. PSI 64/2011 states that post-closure interviews must be conducted within seven days of an ACCT being closed. The post closure interview should have been scheduled for no later than 28 October. We make the following recommendation:

**The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:**

- **Assessing the level of risk and recording the reasons for decisions;**
  - **Setting and recording appropriate levels of observations which are adjusted as the perceived level of risk changes;**
  - **Conducting ACCT reviews as specified in the national instructions;**
  - **Conducting ACCT post-closure interviews as specified in the national instructions.**
55. Mr Collins gave no indication to anyone that he had any suicidal thoughts in the days immediately before 27 October. Two fellow prisoners both told the investigator that Mr Collins appeared his usual self and had given no indication that he had any thoughts of self-harm. We do not consider that staff at Durham could have predicted that he intended to take his own life and, therefore, could not realistically have done anything to prevent his actions.

## New Psychoactive Substances/Illicit Drugs

56. Mr Collins had a history of drug use both in the community and while serving previous custodial sentences. He said he was in debt for drugs and was being threatened. Healthcare staff documented that he appeared under the influence of an illicit substance on 14 October. In the early hours of 15 October, Mr Collins' cellmate assaulted him while the cellmate was under the influence of an illicit substance.

57. Although Mr Collins said on several occasions that he was in debt, he was not prepared to name the prisoners he said were threatening him. Nevertheless, he was moved to a different wing after disclosing the alleged debt. A prisoner said that he saw Mr Collins every day for the two weeks leading up to his death and Mr Collins had not given him any indication that he was using drugs, was in debt or being bullied. An officer said as an A Wing officer he saw Mr Collins on a regular basis, that Mr Collins and the prisoner got on well together and there was nothing to suggest that Mr Collins was in debt or being bullied. The investigator has found no other evidence or intelligence to suggest that Mr Collins was in debt or being bullied.
58. There are concerns that use of NPS can produce a range of bizarre behaviours or paranoia. In the days leading up to his death, Mr Collins did not give any direct indication that he was using NPS and there was no record that his behaviour was out of the ordinary. The assault on Mr Collins by his cell mate does suggest, though, that drugs were present. The post-mortem found evidence that Mr Collins had illicitly acquired prescription drugs but did not indicate any use of NPS. However, the forensic pathologist indicated it was entirely possible Mr Collins had used NPS prior to his death and this had not showed up in the tests.
59. While we can find no evidence that Mr Collins was in debt or being bullied, it is not possible to say whether Mr Collins' actions were influenced either directly by drug use or by a fear of violence resulting from drug-related debt.
60. In July 2015, we published a Learning Lesson Bulletin about the deaths associated with use of NPS. We identified dangers to physical and mental health, as well as risks of bullying and debt and possible links to suicide and self-harm. The bulletin identified the need for better awareness among staff of the dangers of NPS; the need for more effective drug supply reduction strategies; and better monitoring by drug treatment services. While Durham does have a supply reduction strategy, we make the following recommendation:

**The Governor should ensure there are effective supply and demand reduction strategies to help reduce the availability of illicit drugs and new psychoactive substances, and that staff are vigilant to signs of their use and know how to respond when a prisoner appears to be under the influence of such substances.**

### Clinical Care

61. The clinical reviewer considered that, the physical and alcohol detoxification care that Mr Collins received from healthcare staff at HMP Durham was equivalent to the care he could have expected to receive in the community. The reception screening appropriately identified Mr Collins' long term issues with alcohol. Mr Collins' alcohol detoxification was managed appropriately by the substance misuse team and he had good support from medical staff.
62. The clinical reviewer considered that the mental health care Mr Collins received fell short of what he could have expected to have received in the community. The initial response from mental health services was completely appropriate. An ad hoc assessment was performed by a nurse when officers raised concern

about Mr Collins' behaviour. He was subsequently seen two days later by a consultant psychiatrist, who performed a comprehensive assessment using the available information and agreed a care plan for Mr Collins with a nurse. However, the clinical reviewer was concerned that the actions agreed with the nurse were not carried out and there was no clear care plan set out for Mr Collins other than the plan documented by the psychiatrist.

63. We are concerned that following the psychiatrist's assessment on 14 October, no one from the mental health team saw Mr Collins again, despite the agreed care plan. While mental health nurses were present at Mr Collins' ACCT reviews, these are not medical interventions and can not be regarded as such. We make the following recommendation:

**The Head of Healthcare should ensure that the mental health team is adequately resourced to provide a level of service equivalent to that prisoners could expect to receive in the community.**

64. The clinical reviewer was also concerned that the nurse made no record of the ACCT review carried out on the 21 October in Mr Collins' medical record. There was also no clear plan regarding mental health intervention documented in his medical record. He noted that retrospective entries were also made on other occasions by members of the mental health team which is not safe practice. We agree and make the following recommendation:

**The Head of Healthcare should;**

- **Ensure that all staff are aware of the requirement to complete records are completed in an accurate and timely manner;**
- **Undertake an audit of records to ensure that all interventions with prisoners are recorded fully.**

## Emergency Response

65. PSI 03/2013, *Medical Emergency Response Codes*, issued in February 2013, contains mandatory instructions for efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. It explicitly states that all prison staff must be made aware of, and understand, this instruction and their responsibilities during medical emergencies. The PSI also includes a mandatory instruction that the terms of the medical emergency response protocols must be written and agreed in conjunction with the local healthcare commissioner at the prison and the local ambulance trust.
66. Neither officer had a radio when they found Mr Collins hanging in his cell at 11.07am on 27 October. They correctly cut Mr Collins down and immediately started CPR. At 11.13am, the SO correctly used the emergency code. The control room log shows the code blue was called at 11.13am, and the officer said she called for an ambulance immediately.
67. North East Ambulance Service records show they received the 999 call at 11.17am. Paramedics arrived at Durham at 11.25am and took over Mr Collins' care at 11.28am. Earlier intervention would not have changed the outcome for

Mr Collins, however, in future emergencies such a delay may be crucial. We make the recommendation:

**The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 *Medical Emergency Response Codes* and their responsibilities during medical emergencies which ensures staff immediately call for an emergency ambulance when a medical emergency code is used.**

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