Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Glen Adrian, a prisoner at HMP Durham, on 8 March 2023

A report by the Prisons and Probation Ombudsman

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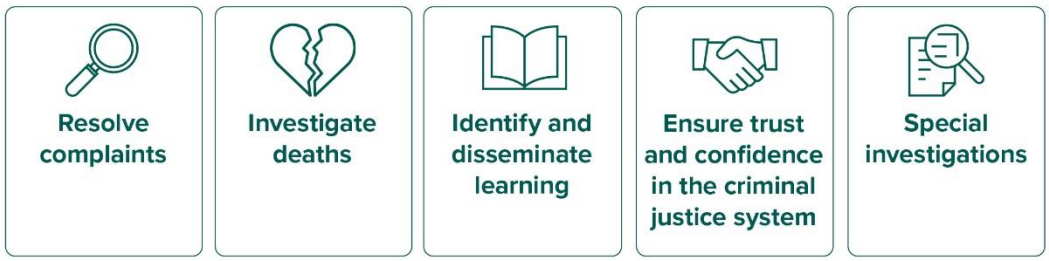
OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Glen Adrian was found hanged in his cell on 8 March 2023 at HMP Durham. He was 27 years old. I offer my condolences to Mr Adrian's family and friends.

Mr Adrian was the seventh prisoner to take his life at Durham in three years and the fourth in four months.

Yet again we found that reception staff did not properly assess the risk of suicide and self-harm when Mr Adrian arrived at Durham. However, it was another seven weeks before Mr Adrian took his life. He gave no indication to staff during that time that he was at risk of suicide. We are satisfied that staff could not have foreseen his actions.

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

Adrian Usher
Prisons and Probation Ombudsman **January 2024**

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Summary

Events

1. On 18 January 2023, Mr Glen Adrian was remanded in prison charged with breaching a sexual harm prevention order. While he was in the escort van being taken to HMP Doncaster, Mr Adrian began banging his head against the inside of the van. The van was diverted to HMP Durham so that he could receive medical attention. A nurse checked him and found only a superficial abrasion. Mr Adrian remained at Durham.

2. Because he had arrived at Durham at around 7.00pm in the evening, Mr Adrian did not have an initial health screen. An officer and supervising officer spoke to him and had no concerns.

3. On 20 January, Mr Adrian had his initial health screen. This took place on the wing, so the nurse did not have access to all Mr Adrian's records. The nurse noted Mr Adrian's history of anxiety and depression and noted that he should be referred to the mental health team. Mr Adrian told the nurse about previous suicide attempts but said he had no current thoughts. The nurse recorded on the medical record that Mr Adrian was being managed under suicide and self-harm prevention procedures (known as ACCT), which was not the case.

4. On 23 January, a nurse triaged Mr Adrian's mental health referral. He noted that the medical record indicated that Mr Adrian was under ACCT management and that therefore he would be seen by mental health staff at ACCT reviews (which was not the case).

5. On 21 February, Mr Adrian appeared in court by video link and was sentenced to ten months imprisonment. An officer spoke to him and did not have any concerns about his wellbeing. He informed the healthcare department that Mr Adrian had appeared in court, so a healthcare assistant also spoke to Mr Adrian and had no concerns.

6. At around 5.30am on 8 March, during a routine check, an officer found Mr Adrian hanging. He called an emergency on his radio and, when other staff arrived, they entered the cell and lowered Mr Adrian to the floor. Mr Adrian was clearly dead, so staff did not attempt resuscitation.

Findings

7. None of the staff who saw Mr Adrian in reception on 18 January started ACCT procedures, despite him having self-harmed in the prison van. We acknowledge that it was another seven weeks before Mr Adrian took his life, but this demonstrates poor assessment of risk by reception staff at Durham, which is an issue we have raised before. We were told in response to a previous recommendation that changes have been made to reception procedures and that further training on risk assessment had been provided to staff.

8. Mr Adrian was seen by a nurse when he arrived, but he did not have an initial health screen. This is an issue we have raised before. We were told that if late

arrival meant that an initial health screen could not take place, it would happen the next day. However, Mr Adrian had to wait a further two days.

9. The nurse who carried out Mr Adrian's initial health screen did not have access to Mr Adrian's PER, and he recorded that Mr Adrian was under ACCT management when he was not. This meant that the nurse undertaking the mental health triage thought that Mr Adrian would be seen by mental health staff as part of ACCT reviews when this was not the case.

Recommendations

- The Head of Healthcare should ensure that:
  - If an initial health screen cannot be carried out on the day of arrival, it is carried out the next day.
  - Records of initial health screens are accurate.
  - Mental health staff assessing prisoners verify whether that prisoner is under ACCT management.

The Investigation Process

10. HMPPS notified us of Mr Adrian's death on 8 March 2023. 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.

11. The investigator obtained copies of relevant extracts from Mr Adrian's prison and medical records. He interviewed nine members of staff at Durham.

12. NHS England commissioned a clinical reviewer to review Mr Adrian's clinical care at the prison. The investigator and clinical reviewer conducted joint interviews of medical staff.

13. We informed HM Coroner for County Durham and Darlington of the investigation. We have sent the Coroner a copy of this report.

14. The Ombudsman's family liaison officer contacted Mr Adrian's mother to explain the investigation and to ask if she had any matters she wanted us to consider. She had no questions but asked for a copy of our report.

15. We shared our initial report with HMPPS. They found no factual inaccuracies.

16. We sent a copy of our initial report to Mr Adrian's mother. She did not notify us of any factual inaccuracies.

Background Information

HMP Durham

15. HMP Durham is a local prison, serving the courts of Tyneside, Durham and Cumbria. It has a maximum capacity of 985 men. Spectrum Community Health CIC provides primary healthcare services. Tees, Esk and Wear Valleys Foundation NHS Trust provides mental health services.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Durham was in November 2021. Inspectors reported impressive improvements since their previous inspection, and that Durham had reduced the supply of drugs and achieved a more than 60% fall in violence. There were concerns that prisoners arriving late or at busy times did not always get full healthcare screenings. Prisoners' healthcare was affected by serious staff shortages in the department. Many prisoners were locked in their cells for long periods. Recorded levels of self-harm were lower than similar prisons and there was good interrogation of self-harm data.

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 latest annual report, for the year to 31 October 2022, the IMB reported that the prison was a safe environment. Improvements were needed to ensure that all prisoners arriving in reception received a healthcare screening. Staffing shortages had impacted on the mental health team.

Previous deaths at HMP Durham

18. Mr Adrian was the eighteenth prisoner at Durham to die since March 2020. Of the previous deaths, ten were from natural causes, one was drug related and six were self-inflicted.

19. We have previously made recommendations about reception staff properly assessing risk. We were told that a meeting was held in July 2023 to review reception procedures and an action plan developed. Training had also been delivered by the National Safety Team on risks, triggers and protective factors.

20. We have also previously made recommendations about the timely provision of initial health screens. We were told that an advanced nurse practitioner would review late arrivals and the initial screen would be completed the next day. However, this did not happen in Mr Adrian's case.

Key worker scheme

21. The key worker scheme is a key part of HMPPS's response to self-inflicted deaths, self-harm and violence in prisons. It is intended to improve safety by engaging with

people, building better relationships between staff and prisoners and helping people settle into life in prison. Details of how the scheme should work are set out in HMPPS's *Manage the Custodial Sentence Policy Framework*. This says:

- All prisoners in the male closed estate must be allocated a key worker whose responsibility is to engage, motivate and support them through the custodial period.
- Key workers must have completed the required training.
- Governors in the male closed estate must ensure that time is made available for an average of 45 minutes per prisoner per week for delivery of the key worker role, which includes individual time with each prisoner.

22. Within this allocated time, key workers can vary individual sessions in order to provide a responsive service, reflecting individual need and stage in the sentence. A key worker session can consist of a structured interview or a range of activities such as attending an ACCT review, meeting family during a visit or engaging in conversation during an activity to build relationships.

23. In 2023/24, due to exceptional staffing and capacity pressures in parts of the estate, some prisons are delivering adapted versions of the key work scheme while they work towards full implementation. Any adaptations, and steps being taken to increase delivery, should be set out in the prison's overarching Regime Progression Plan which is agreed locally by Prison Group Directors and Executive Directors and updated in line with resource availability.

Key Events

24. On 18 January 2023, Mr Glen Adrian was remanded in prison, charged with breaching a sexual harm prevention order.

25. Mr Adrian's Person Escort Record (PER) said that he was to be taken to HMP Doncaster. However, a nurse at HMP Durham told us that Mr Adrian had been banging his head in the escort van and it was diverted to Durham so that Mr Adrian could get medical attention.

26. The escort van arrived at Durham shortly before 7.00pm. The nurse went into the van and assessed the cut to Mr Adrian's head to ascertain whether it was appropriate for him to be held in prison. The nurse assessed that Mr Adrian had a superficial abrasion but was otherwise well. Mr Adrian was admitted to Durham. It was not his first time at Durham, having been released from there in December 2022.

27. An officer saw Mr Adrian in reception for a welfare check. She advised him of support available and how to access it. A supervising officer (SO) also spoke to Mr Adrian in reception. He noted that Mr Adrian said he had no thoughts of suicide or self-harm and that his relationship with his mother was a protective factor. The SO noted that Mr Adrian had good body language and that he had no concerns about him. He did not record that Mr Adrian had been banging his head in the escort van or that he had a head wound.

28. Mr Adrian was not given an initial health screen due to his late arrival. The nurse reviewed Mr Adrian's clinical record and confirmed with prison staff that there were no concerns about Mr Adrian's risk of harm to himself.

29. On 19 January, healthcare staff prescribed Mr Adrian's medication (salbutamol and fluticasone for asthma, and sertraline for anxiety and depression).

30. On 20 January, a nurse carried out Mr Adrian's initial health screen. Because the screening took place on the wing and not in reception, he did not have access to Mr Adrian's PER. He noted that Mr Adrian had a history of anxiety and depression and was prescribed sertraline. Mr Adrian said that he had previously taken overdoses and had attempted to jump off a bridge but had no current thoughts of harming himself. The nurse noted that Mr Adrian was calm and engaged well, though also noted signs of emotional distress. He noted that ACCT procedures had been opened, which was not the case. (At interview, he said that he had used information from a previous health screen by mistake.) He also noted that Mr Adrian needed a referral to the mental health team.

31. On 23 January, a member of the healthcare administration staff noted that no mental health referral had been made for Mr Adrian. She made a referral, and a nurse carried out a mental health triage. He noted Mr Adrian's recent suicide attempts and that he had worked with the mental health team in the past. He noted that Mr Adrian was on an open ACCT and would be seen as part of the ACCT process (which was based on the incorrect entry made during the initial health screen). He referred him to ReThink, a charity that provides mental health services.

32. On 28 January, a SO introduced herself to Mr Adrian as his prison offender manager (POM). Mr Adrian said that he had been in custody before so was aware of the support available to him. He reported good family ties in the community via his mother. He said that he was struggling for money in custody and could not afford any vapes. She advised him how to apply for a job using the prisoners' electronic kiosk system. Mr Adrian told her that he had no concerns but was aware of how to contact her if he needed anything. She noted that Mr Adrian had been allocated a key worker but had not had any contact with him so far.

33. On 21 February, Mr Adrian appeared in court by video link and was sentenced to ten months imprisonment for breaching a sexual harm prevention order. An officer spoke to Mr Adrian afterwards. They discussed his sentence and how much longer he would likely have to remain in prison. In interview, the officer said that he did not have any concerns about Mr Adrian's wellbeing. He informed the healthcare department that Mr Adrian had had a video link court appearance, so a healthcare support worker spoke to Mr Adrian at his cell door. He told her that he was okay, and she did not note any concerns.

34. On 28 February, the POM attended a Multi-Agency Public Protection Arrangements (MAPPA) meeting and discovered that Mr Adrian had previously committed a sexual assault on a cellmate. As a result, Mr Adrian's cell sharing risk assessment was reassessed from standard to high risk and he was moved to a single cell.

35. On 2 March, Mr Adrian wrote to his probation officer. He set out some actions he hoped would help him settle back into society on release. He also said that he was struggling being back in prison as he was ashamed of himself. Mr Adrian did not make any phone calls or receive any visits during his time at Durham.

36. At around 8.45pm on 7 March, during a routine check, Officer A saw Mr Adrian in his cell and had no concerns. Prisoners later told staff that they heard what sounded like Mr Adrian moving furniture at approximately 11.00pm.

37. Staff do not conduct checks on prisoners at night unless there are specific safety or medical checks to be made, or if the prisoner activates his cell bell or otherwise attracts staff attention. None of these applied to Mr Adrian, and staff did not have any interaction with him during the night.

Events of 8 March

38. At 5.29am on 8 March, during a routine check, Officer A saw Mr Adrian suspended by a ligature made from a blanket tied to the bedframe.

39. Officer A radioed a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties). Staff responded and the control room called an ambulance. A nurse arrived first. Body worn video camera (BWVC) footage shows her looking through the observation panel and saying, "He's hanging".

40. Officer B arrived and used his radio to ask a custodial manager (CM), who was the officer in charge at that time, for permission to open the door. The CM gave permission, but Officer B was unable to open the sealed pouch in which night officers carry keys for emergency use. The nurse handed him her key and he

unlocked the door, and the staff went into the cell. He tried to cut the blanket with his anti-ligature knife, but it was too thick to cut, so another nurse supported Mr Adrian's weight while he removed the ligature from his neck. They lowered him to the floor.

41. Both nurses assessed Mr Adrian, but he showed no signs of life and appeared to have been dead for some time. They did not therefore attempt to resuscitate him. At 5.41am, paramedics arrived. At 5.42am, they confirmed that Mr Adrian had died.

Contact with Mr Adrian's family

42. The prison appointed two family liaison officers. They travelled to Mr Adrian's mother's home and informed her of her son's death. They remained in contact with her to provide support. In line with guidance, Durham offered a contribution to the cost of Mr Adrian's funeral.

Support for prisoners and staff

43. After Mr Adrian's death, the duty governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

44. The prison posted notices informing other prisoners of Mr Adrian's 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 Adrian's death.

Post-mortem report

45. The post-mortem report concluded that Mr Adrian died from hanging.

Findings

Assessment of Mr Adrian's risk of suicide and self-harm

46. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody),* contains national requirements on the assessment and management of suicide and self-harm risks in prisons. The instruction lists risk factors and potential triggers that staff should be alert to and act appropriately to address. Any prisoner identified as at risk of suicide and self-harm must be managed under ACCT procedures.

47. No one started ACCT procedures for Mr Adrian when he arrived at Durham on 18 January 2023, despite him having self-harmed by banging his head in the escort van. Neither of the officers who saw him in reception even noted that he had been banging his head. The nurse who assessed his head injury did not consider ACCT procedures either. We acknowledge that it was another seven weeks before Mr Adrian took his life, but this demonstrates poor reception screening by staff at Durham.

48. Inadequate reception screening is an issue we have raised with Durham before. We were told that in July 2023, a meeting was held between prison and healthcare staff to review reception processes. Following that, an action plan had been produced and changes had been made to ensure that staff access and consider all relevant risk information. Training had also been delivered to staff on assessing risk of suicide and self-harm. We make no recommendation.

49. Mr Adrian gave no indication to staff that he was at risk of suicide or self-harm after he had arrived at Durham.

Clinical care

50. Mr Adrian was seen by a nurse when he arrived at Durham, but he did not receive an initial health screen until two days later. The clinical reviewer noted that the delay in Mr Adrian receiving a reception health screen meant that staff did not have the opportunity to make an early assessment of any risks to his health and wellbeing.

51. The lack of an initial health screen for late arrivals at Durham is an issue we have raised before. In January 2023, we were told that prisoners who arrived late and could not receive their initial health screen, would be reviewed by an Advanced Nurse Practitioner and that the screening would be completed the next day. However, this did not happen in Mr Adrian's case, as he did not get his initial health screen until 20 January, two days after he arrived.

52. The nurse who carried out Mr Adrian's initial health screen noted that Mr Adrian was under ACCT management, which was not the case. This note informed subsequent healthcare staff's assessments of Mr Adrian, and a referral to the mental health team was delayed as there was an assumption that he would be assessed as part of the ACCT process. The clinical reviewer noted that while it is not possible to say whether this affected Mr Adrian's death, it may have resulted in a different treatment pathway.

53. We recommend:

The Head of Healthcare should ensure that:

- **If an initial health screen cannot be carried out on the day of arrival, it is carried out the next day.**
- **Records of initial health screens are accurate.**
- **Mental health staff assessing prisoners verify whether that prisoner is under ACCT management.**

54. The clinical reviewer concluded that with the delayed initial health screen and the errors noted within it, the physical care provided to Mr Adrian was not equivalent to that which he could have expected in the community. The incorrect noting of Mr Adrian being under ACCT management consequently meant that his mental healthcare fell below that which he could have expected in the community.

Key work

55. Prisoners should have around 45 minutes of key work with an allocated officer each week. Although Mr Adrian was told that he would be allocated a key worker, his prison record shows that he had no key worker sessions in his seven weeks at Durham. The CM responsible for key work at Durham said in interview that the prison faced various pressures, including staffing levels and the high number of prisoners who arrived in a large local prison. This meant that they had to prioritise key work sessions for prisoners who were the most vulnerable. Durham was continually assessing the scheme and were working to introduce a first key work session as part of prisoners' second day induction programmes.

Governor to Note

Emergency response

56. Policy on access to cells during the night is contained in Prison Service Instruction (PSI) 24/2011 *Management and Security of Prisons at Night* and Durham's local security policy. Staff should not open a cell without permission from the officer in charge of the running of the prison and only when other staff are present. Staff may, however, enter a cell without authority or support in an emergency to preserve the life of a prisoner. They should make a dynamic risk assessment, and only unlock the cell if they feel safe to do so.

57. There was a delay of around two minutes between Officer A finding Mr Adrian hanging, and staff entering the cell. In interview, Officer A said that he did not consider entering the cell as he did not think he was allowed to do so. Mr Adrian had been dead for some time by this point, so the outcome was not affected. Nonetheless, in other cases quick action could be vital, and it is important that staff know this. We bring this to the Governor's attention.

Good practice

58. On 21 February, Mr Adrian was sentenced to ten months imprisonment. Staff spoke to him afterwards to check on his welfare, as did a healthcare assistant, and no concerns were identified. This was good practice.

59. Several staff responding to the emergency activated their body worn video cameras. This was good practice and provided us with good quality evidence.

Inquest

60. The inquest, held from 25 to 28 November 2024, concluded that Mr Adrian died by suicide.

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