Report of an Independent Investigation into the Case of SR commissioned by the Secretary of State for Justice in accordance with Article 2 of the European Convention on Human Rights

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Glossary

Bed watch	a hospital admission of at least one night in length, during which the prisoner requires constant supervision for security purposes
CAB	Challenging Anti-Social Behaviour
CCTV	Closed-Circuit Television
Category B	The category of prisoners for whom the highest conditions of security were not necessary but for whom escape must be made very difficult (definition in use in 2015)
Category C	The category of prisoners for who could not be trusted in open conditions but who do not have the resources and will to make a determined escape attempt (definition in use in 2015)
CCTV	Closed-Circuit Television
CNA	Certified Normal Accommodation (Uncrowded capacity is the Prison Service's own measure of accommodation). CNA represents the good, decent standard of accommodation that the Service aspires to provide all prisoners
Code Blue	Medical Emergency Response Code that enables staff discovering a prisoner who is exhibiting breathing difficulties to ensure that healthcare staff bring appropriate equipment and the Control room are notified.
CSRA	Cell Sharing Risk Assessment
DART	Drug and Alcohol Recovery Team – a free and confidential service for adult offenders and their families in the North East of England

Detox	Abbreviation for detoxification. The intervention during period of withdrawal from addictive substance, usually heroin
Dynamic Security	Concept and working method by which staff prioritise the creation and maintenance of everyday communication and interaction with prisoners (introduced by Ian Dunbar in 1985)
ECHR	European Convention on Human Rights
FNIP	First Night in Prison
F213	Report of Injury to a Prisoner
HMCIP	His Majesty's Chief Inspector of Prisons
HMPPS	His Majesty's Prison and Probation Service
Hotel	The radio call sign for a Healthcare Officer or Nurse
IEP	Incentive and Earned Privileges
IRS	Incident Reporting System
IMB	Independent Monitoring Board. A group of members of the public who monitor the day-to-day life in their local prison or removal centre and ensure that proper standards of care and decency are maintained. IMB members are independent and unpaid
IDTS	Integrated Drug Treatment Services
Methadone	An opioid used for opioid maintenance therapy
NOMS	National Offender Management Service, an executive agency responsible for making sure that people serve the order handed

	out by the courts, both in prisons and the community. (On 1 April 2017 NOMS was replaced by HM Prison and Probation Service)
Operational Capacity	The total number of prisoners that an establishment can hold taking into account control, security and the proper operation of the planned regime
PGA	Prison Governors' Association
PNC	Police National Computer
POA	Prison Officers' Association (Trade Union)
PTSD	Post traumatic stress disorder
Prison-NOMIS	Prison National Offender Management Information System, abbreviated to P-NOMIS and shortened to NOMIS. An operational database containing offenders' personal details, offences and case history, et cetera
SIR	Security Information Report. A form for describing what they have seen, heard, found etc. This was either placed in a box or, if urgent, taken by hand to security or a senior manager in the prison. The SIR would be evaluated and appropriate action directed/taken
Smokers' pack	An emergency allocation of tobacco
SystmOne	A clinical software brand supporting the 'one patient, one record' model of healthcare
Unannounced Inspection	Prison inspection carried out without notice to a prison following up the recommendations of a full announced inspection

Executive Summary

On 6 October 2014, SR was remanded into custody at HMP Durham charged with an offence of attempted burglary. At the time he was also subject to a post custodial licence having been released from an earlier prison sentence.

Following reception, he was allocated a cell on F Wing and subsequently moved location on a number of occasions. SR was assessed as safe to share a cell and was not perceived to be a risk to other prisoners or staff. Health screening indicated significant problems with alcohol and some concerns about drug use.

SR was considered by prison officers to be immature for his years and did exhibit some control problems which needed to be managed. He was sanctioned for his behaviour and at times refused to attend work or education. He was also involved in the production and possession of homemade alcohol.

On 26 March 2015 FC was remanded to HMP Durham for an alleged offence of robbery. FC had a significant criminal record, a history of mental health problems and a propensity for violence. On reception FC was accommodated on E Wing instead of the normal first night area because of previous threats to an officer on that unit. During his short time in HMP Durham FC was taken to the segregation unit on more than one occasion because of his aggressive behaviour. This behaviour should have alerted staff to the risk FC posed to others and the subsequent failure to implement the provisions of the prison's Violence Reduction Strategy was a missed opportunity to reduce the likelihood of FC assaulting SR.

On the morning of 16 April 2015, SR was unlocked from his cell and allowed a period of association with other prisoners. It was at this time SR entered the communal showers on the Wing. In the shower he was seriously assaulted by FC and sustained life changing injuries. The entrance to the shower block was observed by prison officers, but for reasons of privacy, the internal shower cubicles were not overseen. At the time of the assault staff were probably away from the entrance to the showers but even if they had been present the assault may still have occurred because they could not see the interior showers.

Prison Officers and Health Care staff responded promptly and administered first aid prior to arrival of paramedics and SR was then transferred by ambulance to hospital. Although there were a number of other prisoners in the showers FC was soon identified as the perpetrator of the assault. Prison staff segregated FC from other prisoners, the police were informed and started a criminal investigation given the severity of the assault.

HMP Durham were not able to produce a cell sharing risk assessment for FC and there was little documentation relating to the possible risk FC posed to other prisoners. Although few if any formal mitigations were put in place to manage his risk, it was clear that most staff were aware that, although not dissimilar to many other prisoners, FC was a damaged and violent man.

Supervising prisoners on association in a Victorian prison (without in-cell facilities) with a relatively small number of staff is difficult. FC took advantage of this situation to assault SR at time when staff were stretched and having to cope with a large number of prisoners. The risk of such assault can be reduced by managing egress and exit from communal showers in an orderly way.

The motivation for the assault on SR by FC is not entirely clear, but it appears likely that FC carried it out at the request of another person to whom SR owed money. Opportunities were missed in the weeks before the incident to monitor and control FC more effectively, but there is no evidence to suggest that prison staff had prior intelligence that SR could have been at risk of assault from FC. However, given FC's history of violence there was always the potential for him to be violent and therefore the assault on SR was in one sense predictable. How far it could have been prevented is a more difficult question to answer. On balance, the conclusion is that better assessment and recording of the risk of harm a prisoner poses to others, increasing the number of staff supervising prisoners on association and improving the management of showering arrangements may have reduced the risk in this case but would never have totally eliminated it.

FC was subsequently given a custodial sentence for Grievous Bodily Harm.

Following serious assaults and other incidents, prison staff are required to undertake a number of reporting and review activities in order to ensure that relevant staff are held to account and learning takes place. We found that these activities had been completed except that a full investigation was not completed when it became apparent that SR had sustained life-changing injuries.

In this report of our investigation, we make a total of eleven findings and seven recommendations.

List of Finding

Finding

In summary, SR received healthcare in HMP Durham equivalent to that which he would have had were he in the community.

Finding

We take the view that the needs and the risks SR posed were adequately identified by prison staff; they assessed him correctly as a young man who, whilst immature, did not present a significant risk to himself or others.

Finding

We cannot be certain if there was an unacceptable delay in calling the emergency Code Blue for medical assistance because we did not have the relevant records. We also note that initially an officer thought that SR had a fit. However, we take the view that prison and in-house health care staff responded effectively and professionally to the incident once they realised the seriousness of it. Some concerns were expressed by the health care staff about the way SR was transferred to the ambulance by paramedics.

Finding

In summary, FC received healthcare in HMP Durham equivalent to that which he would have had were he in the community, although the failure to complete full psychiatric assessments during earlier sentences may have been a missed opportunity.

Finding

The risk that FC posed to other prisoners was not clearly recorded and articulated.

Finding

The failure to follow the procedures set out in the Violence Reduction Strategy was a significant failing. If steps had been taken to interrupt FC's aggressive behaviour the likelihood of the assault taking pace would have been reduced.

Finding

There is a fine line between ensuring safety and ensuring privacy when supervising prisoners in an antiquated Victorian prison which does not have modern in-cell facilities. FC took the opportunity to assault SR when the entrance to the showers was probably not monitored by staff. Given the fact that staff could not physically go into the cubicles he still may have carried out the assault, but their temporary absence may have emboldened him. We are also concerned that staff may have been conditioned into accepting prisoners entering and leaving the showers on a frequent basis. We were not completely satisfied that the area was being properly supervised when staff were present.

Finding

We found that the level of staffing on the wing at the time made oversight difficult of a crowded and at times chaotic situation.

Finding

FC was managed properly after the incident and commendable efforts were made to secure the evidence required to help secure a conviction.

Finding

A full investigation was not completed when it became apparent that SR had sustained life-changing injuries as a result of the assault.

Finding

Few if any staff accessed staff care services following the incident.

List of Recommendations

Recommendation 1 to HMP Durham

In order to reduce the risk of harm posed by prisoners to other prisoners' Cell Sharing Risk Assessments should be better recorded and steps to mitigate risk of harm clearly stated. In addition, there should be a system for retrieval of the document upon request.

Recommendation 2 to HMP Durham

In order to reduce the risk of violence to prisoners the Violence Reduction Strategy should be monitored by managers to ensure that all prisoners to whom it applies are included and steps taken to reduce their likelihood of potential violence.

Recommendation 3 to HMP Durham

In order to reduce congestion in and around showers and make observation easier HMP Durham should introduce a prisoner reservation booking system for the use of showers.

Recommendation 4 to HMP Durham

HMP Durham should review the minimum staffing level needed to safely oversee prisoners taking part in association.

Recommendation 5 to HMPPS

As a considerable time may pass before an Article 2 investigation is commissioned, HMPPS should clarify whether the prison is responsible for completing a full investigation where serious harm to an individual has been sustained.

Recommendation 6 to HMPPS

As the impact on staff well-being of traumatic incidents may not be immediately apparent, all staff should be actively encouraged by their managers to access staff care services following such incidents.

Recommendation 7 to HMPPS

HMPPS takes steps to reduce the time between incidents and the commission of Article 2 Investigations.

Recommendation 8 to HMPPS

HMPPS should ensure that liaison between Article 2 investigators and prisons is improved by ensuring that the member of staff in an establishment appointed to liaise: a) understands the nature of the Article 2 process, and b) is of sufficient seniority to direct staff and resources to facilitate the investigation.

Part 1 The Investigation

1.1 How we conducted the investigation

Andy Smith, former Assistant Chief Inspector of Probation, assisted by Louise Taylor, a retired Governor from the Prison Service, conducted the investigation. Cheryl Carson and Duncan Moore, experts on prison health care services reviewed the medical records of the victim and perpetrator and provided a summary of key clinical issues.

The investigation was commissioned on 23 February 2021 by Andy Rogers of His Majesty's Prison and Probation Service (HMPPS) Safer Custody and Public Protection Group, who represented the Secretary of State for Justice in this matter, as the Commissioning Authority for independent investigations into incidents of serious self-harm or serious assaults.

It should be noted that at the time of the incident the National Offender Management Service (NOMS) was the executive agency responsible for prison and probation services across England and Wales. On 1 April 2017 His Majesty's Prison and Probation Service (HMPPS) replaced NOMS as the executive agency responsible for delivering prison and probation services.

I was commissioned by the Secretary of State for justice to conduct an investigation with the following terms of reference[1]:

- to examine the circumstances of the incident on 16 April 2015 in which SR sustained a life-threatening injury, and, in so far it is relevant, his management by HMP Durham from the date of his reception on 6 October 2014 until that date in light of the policies and procedures applicable to at the relevant time;

- to examine the role of FC in the incident, and, in so far as it is relevant, his management by HMP Durham from his reception on 26 March 2015 until the incident on 16 April 2015 and any relevant intelligence;

[1] Commissioning Letter from Andy Rogers to Andy Smith dated 23 February 2021

- to examine relevant health issues during the periods spent in custody at HMP Durham by SR and FC, including mental health assessments, and their clinical care up to the point of the incident on 16 April 2015;

- to consider, within the operational context of the Prison Service, what lessons in respect of current policies and procedures can usefully be learned and to make recommendations as to how such policies and procedures might be improved;

- to provide a draft and final report of findings including the relevant supporting documents as annexes;

- to provide a view, as part of the draft report, on what is considered to be an appropriate element of public scrutiny in all the circumstances of this case. The Secretary of State will take this view into account and consider any recommendation made on this point when deciding what steps will be necessary to satisfy this aspect of the investigative obligation under Article 2 of the ECHR.

Louise Taylor and I conducted a detailed examination of the records that were initially disclosed to us pertaining to SR and FC. The relevant findings of the clinical reviews have also been incorporated into this report.

An Article 2 investigation of this nature should seek to ascertain the views of the victim's family and to this end we met with the mother of SR and his sister. They had a number of concerns. SR's mother wanted to know why her son was assaulted and how it had happened given the close proximity of prison officers. She was also concerned that she had been told that it took 15 minutes to discover that he was unconscious in the shower. She asked why there not an Officer in the shower area since it is a risky area, The CCTV showed that FC gave him a punch on the stairs and SR's mother asked why this was not challenged. MS said she did not understand why there were two officers when SR was in a coma. They were told he would be handcuffed if he came round even though he was not capable of going anywhere. They took photographs but were told that they had to be deleted. They felt that SR

was treated as a prisoner rather than a patient because the Officers were there. This happened for three weeks until the family pressed for bail to be granted.

A chronology of the events leading up to the assault on SR was prepared[2].

At an early stage, letters explaining the nature of the investigation and our Terms of Reference were sent to the Independent Monitoring Board (IMB), Prison Governors' Association (PGA) and Prison Officers' Association (POA) at HMP Durham.
We subsequently interviewed ten members of staff at HMP Durham. We also visited the scene of the assault and also viewed the route the ambulance would have taken.

We were provided with the Police Report (MG5) which related to the assault[3].

We also received medical records from Spectrum Community Health CIC which operated General Practitioner and Pharmacy services at the time of the incident and from G4S Health Services which held responsibility for primary nursing care. G4S Health Services demobilised their contract with the prison in March 2020, but Spectrum Community Health Services CIC continue to provide a service.

1.2 HMP Durham

HMP Durham is a large, Category B Victorian local prison for adult prisoners and young offenders. The prison holds sentenced, convicted and remand males over 18 years mainly from Cumbria, Northumberland and County Durham and primarily serves the courts. There are usually about 11% young offenders in the establishment. The alignment of Durham Court's catchment area means the prison is holding most prisoners close to their homes; 90% of prisoners come from this catchment area.

As a local prison, HMP Durham's role is to assess all prisoners, to accommodate those prisoners serving short sentences as well as those on remand, and to introduce prisoners serving longer sentences to their journey through the prison system. It is not

[2] Chronology dated 22 Feb 22
[3] MG5 2016 Police Report on F

a training prison and the regime is therefore not designed for those serving long sentences.

Prison capacity is measured by two figures, namely the Certified Normal Accommodation (CNA) and the Operational Capacity. The CNA figure records the ideal maximum population of the prison if there was no overcrowding. In October 2015, the CNA for HMP Durham was 595.

The Operational Capacity relates to 'that population which could be accommodated without risk of disruption through overcrowding'. For Durham, the Operational Capacity is 995.
The average overall population during the reporting period was about 930 males. Thus the majority of prisoners are held two to a cell intended for sole occupancy.[4]

1.3 HM Inspectorate of Prisons

HM Inspectorate of Prisons carried out inspections of HMP Durham in 2013 and 2016.

The earlier inspection report observed that:

Durham operates with the challenge of working with, and holding people in, an aged infrastructure, where virtually every cell is holding more people than it should.

Significantly the Chief Inspector also concluded that:

For a local prison receiving people from the streets and new to custody, arrangements to promote safety were not good enough.

On a more positive note, he added that:

The prison had recently opened a brand new health facility and we found outcomes that were encouraging. Mental Health provision was excellent.[5]

The report of the 2016 inspection was described as 'disappointing'[6]

[4] Report of The Independent Monitoring Board HMP Durham Annual Report 1 November 2014 to 31 October 2015, p4
[5] Report of an Unannounced Inspection of HMP Durham 2-13 December 2013, Nick Hardwick, HM Chief Inspector of Prisons p.5-6, May 2014
[6] Report of an Unannounced Inspection HMP Durham 13-14 October 2016, Peter Clarke, HM Chief Inspector or Prisons p 6, January 2017

The prison was still not safe enough…In our survey there was evidence to suggest that more prisoners now felt unsafe than during previous inspections.[7]

The prison had many strengths, not least a strong local identity and generally friendly staff, but the culture was not as constructive or purposeful as it should have been. It was striking how little had changed since our last inspection, with a passivity, even complacency, about what was needed to take the prison forward.[8]

1.4 Independent Monitoring Board

The Annual Report for the HMP Durham Independent Monitoring Board Report for the relevant period under investigation made several positive observations about the prison.

The prison has many areas of excellence and there has been a marked improvement in many areas over the past year…. Care for the prisoners is apparent throughout the prison though more evident in some areas than others. There is a clear focus on prisoners' engagement and future re-integration into the community, starting by giving them opportunities to participate in supporting each other and running the prison through work, focus groups and roles they perform as listeners, induction of new prisoners, representatives on committees, PIDs, etc. The Governor is to be congratulated on the leadership he has exercised in achieving this.[9]

All instances [of violence] are reported. CCTV evidence is used in adjudications or made available to police. Instances are investigated by the safer custody team an appropriate action taken. There is a strong message in the prison that bullying, physical violence and intimidation will not be tolerated. Support plans are put in place for victims and perpetrators. Prisoners who behave aggressively or are violent may be confined in the SACU to await adjudication.[10]

[7] Report of an Unannounced Inspection HMP Durham 13-14 October 2016, Peter Clarke, HM Chief Inspector or Prisons p 5, January 2017

[8] Report of an Unannounced Inspection HMP Durham 13-14 October 2016, Peter Clarke, HM Chief Inspector or Prisons p 6, January 2017

[9] The Independent Monitoring Board HMP Durham Annual Report 1 November 2014 to 31 October 2015, page 6.

[10] The Independent Monitoring Board HMP Durham Annual Report 1 November 2014 to 31 October 2015, page 18

Part 2 The events in detail

2.1 Background: SR

SR has a number of convictions and has been sentenced to previous terms of imprisonment. In November 2011, he was convicted of a sexual offence, but successfully appealed this conviction on 28 May 2012[11]. On 19 July 2013 he was released on licence from HMP Northumberland. On 4 October 2014, aged 23 (while still subject to licence) he was arrested for an alleged offence of attempting to enter a dwelling as a trespasser[12]. He appeared before Newcastle-upon-Tyne Magistrates' Court on 6 October and was remanded in custody to HMP Durham because he was deemed likely to reoffend due to his criminal record, personal background and character. SR was then committed to Newcastle-upon-Tyne Crown Court[13].

2.2 Reception and subsequent location 6 October 2014 – 16 April 2015

The reception Log (NOMIS) records that SR arrived at HMP Durham at 17:09[14]. He was received on F Wing from reception, given full induction and signed 'all compacts'. A telephone PIN number was issued, and he was given a small smoker's pack. He was reported to be polite to staff on induction[15]. He was assigned to cell F4-026[16]. He was subsequently moved to a number of different cells in the period up to the incident 16 April.

The NOMIS transfer report on SR records that he was seen as part of the induction by the Drug and Alcohol Recovery Team (DART) on 7 October; he declined to engage with the service stating there was no substance misuse need. Harm reduction information was discussed, and an information sheet provided[17]. On 16 October he confirmed that he did not wish to make representations against recall for the breach of his licence conditions.[18]

On 5 November, Learning and Skills staff requested that SR be placed onto the IEP Basic Regime due to non-attendance at the functional skills education class on the morning of 31 October[19]. Four days later he was downgraded to a Basic Regime as part of the Incentives and Earned Privileges (IEP) scheme[20].

[11] SR Custodial Documents file 2
[12] SR Criminal Justice Act 2003 Licence
[13] SR Location Card
[14] SR Reception Log
[15] SR HMP Northumberland 14-day check
[16] SR Person Escort Form
[17] SR NOMIS Transfer Report, page 9
[18] SR NOMIS Transfer Report, page 8
[19] SR NOMIS Transfer Report, page 8
[20] SR NOMIS Transfer Report, page 8

On 7 November SR pleaded guilty via video link to court to an offence of Attempted Burglary[21].

SR was upgraded to the IEP Standard Regime on 24 November following a period of good behaviour[22]. However, on 25 January, he was found in possession of five litres of 'Hooch' in his cell and placed on report. The following day he was punished by Stoppage of Earnings[23]. On 8 March, SR was found in possession of 'Spice' in his cell and placed on report. It was noted that: he was very incoherent and not at all his usual self very red eyed and could not string a sentence together. Other drug paraphernalia was found in his cell plastic bag with what looked like it had contained a white powder[24].

On 11 March he was downgraded to Basic Regime after refusing to work, but by 2 April an IEP review upgraded to Standard Regime in view of his improved behaviour[25].

On 11 April SR was selected for a random drug test; no concerns were identified[26].

An extract from Mercury Intelligence states that a list of seven prisoners' (including SR) names were found in cell being cleared[27]. This was identified as possibly a list of debtors.

2.3 Assessment of needs and risks: SR

We do not know if a Basic Custody Screening was completed in respect of SR.

A Cell Sharing Risk Assessment was completed. The document raises no contra indication about SR's cell sharing risk and states that he can 'cell share due to capacity'[28].

On 9 October a labour allocation review assessed SR as Low Risk[29]. On 16 October a categorisation review confirmed that SR would remain at Category C. Category C was used for 'who cannot be trusted in open conditions but who do not have the resources and will to make a determined escape attempt.'[30]

The following boxes were ticked on the review: danger to staff, prisoners and other persons. A risk of self-harm was noted, and he was still a MAPPA nominal, reflecting his previous offending[31]. However, although SR was deemed to be a category C for

[21] SR Remand Order 7 November 2014
[22] SR NOMIS Transfer Report, page 8
[23] SR NOMIS Transfer Report, page7
[24] SR NOMIS Transfer Report, page 7
[25] SR NOMIS Transfer Report, page 7
[26] SR NOMIS Transfer Report, page 6
[27] Mercury Intelligence Report dated 23 March 2015
[28] SR CSRA 06 October2014
[29] SR NOMIS Transfer Report, page 8
[30] PSI 40/2011 Categorisation and Recategorization of Adult Male Prisoners
[31] Review of Adult Male Prisoner's Categorisation – Licence Recall

the offence for which he was recalled, he was separately held on remand for other offences and as a result would remain category B, which at the time was the category of prisoners 'prisoners for whom the very highest conditions of security are not necessary but for whom escape must be made very difficult'[32].

Perhaps the most notable comments garnered from the disclosed documents reflect SR's immaturity and attitude. On 24 March 2015, a Personal Officer entry commented:

'SR has a very negative attitude. he is currently on basic due to refusal to attend work after coming to A wing from B wing. I find he is compliant to instructions, but I tend to tell him a couple times before he is very immature for his age[33].'

Furthermore, on 28 March 2015 an officer wrote:

'[SR] is a stubborn self-centred individual who is totally dis-interested (sic) in abiding by prison rules and regulations. He seems to have a 'couldn't care less' attitude and refuses to work. He is not a control problem as such; however, he has a poor attitude'[34].

2.4 Health Care: SR

On arrival at HMP Durham prison reception, SR underwent a healthcare reception screening and First Night in Prison (FNIP) risk assessment. This is in line with the NHS England and NHS Improvement Service Specification, Primary Care Service-medical and nursing for prisons in England, 2020. This standard was also in place in 2015.

At the healthcare reception screening, very high alcohol consumption was disclosed[35]. SR was identified as having issues with alcohol whilst in the community and was referred appropriately to the prison substance misuse services (Integrated Drug Treatment Services, IDTS), despite SR not showing any evidence of alcohol withdrawals.

His urine was also tested for illicit substances and was negative for everything except benzodiazepines. These were given whilst he was in custody. The first full first reception health screen completed on 6 October concluded that SR was 'not suitable for in-possession medication'[36].

A member of Healthcare staff, designated as Hotel 4 observed him overnight on 6 October 2014. This is good practice with people who may have a physical dependency on alcohol.

[32] PSI 40/2011 Categorisation and Recategorization of Adult Male Prisoners
[33] SR NOMIS Transfer Report, page 6
[34] SR NOMIS Transfer Report, page6
[35] Clinical Review SR
[36] Clinical Review SR

After seeing substance misuse services and the GP on 7 April 2015, SR did not require any further medical intervention for his alcohol issues and was referred to the psychosocial services for substance misuse. This is good practice, as described in the Models of Care for Alcohol Misusers (Department of Health/National Treatment Agency for Substance Misuse 2006).[37]

The GP described him as a 'totally vague historian – cannot remember last night' 'totally vague about cannabis, cocaine and alcohol – unable to specify amounts'[38]

SR also complained of toothache and was given appropriate analgesia and asked that he refer himself to dental services, which he refused.

A secondary healthcare screen was carried out on 8 April 2015; again this was commensurate with NHS prison healthcare requirements.

2.5 Background: FC

FC has a significant criminal history, most notably for offences of violence which led to the imposition of custodial sentences. When serving previous sentences FC had exhibited violent and troubling behaviour. In 2010 an OASYs assessment had placed him at High Risk of Serious Harm and subject to MAPPA. In addition, the alerts page of FC's NOMIS transfer report comprises six pages which identify mental health concerns, assaults on staff and prisoners, weapons, arson, threats to staff and 'dirty protests'[39]. On 9 March 2014 a review of his CSRA noted a suspected assault on a cell mate and he was not to share a cell[40].

On 26 March 2015 FC, aged 29 was remanded to HMP Durham as an unconvicted prisoner by Newcastle-upon-Tyne Magistrates' Court. He was alleged to have committed an offence of Robbery.

2.6 Reception and subsequent location 26 March – 16 April 2015

The prisoner escort record indicates that FC was received at HMP Durham at 16:08 on 26 March. It states that he threatened to assault staff. He also is quoted as saying that he would:

"Slash the grasses up in town tonight"[41].

Despite requests for the document, we have not been supplied with the CSRA which was completed on FC at the time of reception. The NOMIS Transfer Report entry for

[37] Models of Care for Alcohol MisuseSR (Department of Health/National Treatment Agency for Substance Misuse 2006)
[38] Clinical Review SR
[39] FC NOMIS Transfer Report, pages 3 - 8
[40] FC CSRA March 2014
[41] FC Person Escort Form dated 26 March 2015

26 March states that the calculated CSRA result for FC was 'standard risk, no concerns'[42]

FC was seen on induction and a PIN and smokers pack was issued. At 16:46 he was assigned to cell E2-014. A communication entry on NOMIS dated 27 March comments as follows:

'Whilst on a previous sentence FC had made threats towards Officer X due to this reason [FC] was located on E wing and not the first night centre on his arrival into custody. [FC] was brought over to the first night centre where he received his smokers pack and pin number and was seen by the doctor, he was them returned to E wing. [FC] has previous experience of the induction process so staff have had a chat with him to ensure he understands what is happening and what is expected of him but he will not be spending time on the first night centre at present'[43]

FC was also seen by DART as part of his induction but declined to engage.

On 28 March FC was taken to the Separation and Care Unit (SACU) and placed on report after deliberately damaging his cell. FC was deemed to be at risk of self-harming and an ACCT was opened and subsequently closed after reviewing a day later. By then FC had reportedly calmed down, apologised and stated that he wanted to use time constructively.

A NOMIS entry on 29 March commented that:

'It is believed by staff that FC has engineered his location to the SACU due to wanting to assault [another prisoner], SACU cleaner … who has an ongoing high profile local case where money has been put on his head. Obs [Observation] book has been updated and Security [Officer] made aware and he is to submit an IR'[44]

FC requested to see a chaplain on 4 April and mentioned that his girlfriend was seriously ill and was not sure how long she may live, she was not allowed to visit him currently due to just been released from a female prison. The Chaplain advised him to submit an application to the security department to request a visit. He told him that he could not guarantee if security will approve this.[45]

On 8 April, FC was again moved to the SACU (not under restraint) due to being under suspicion of being in possession of a weapon. He was reported to be noncompliant and abusive on arrival[46] He was assigned cell G1-006 at 13:46 in SACU and at 16:45 he was sent to cell A5-011, out of SACU. A further cell move took place at 9:02 on 14 April to cell A1-004.

[42] FC NOMIS Transfer report, page 212
[43] FC NOMIS Transfer report, page 204
[44] FC NOMIS Transfer report, page 203
[45] FC NOMIS Transfer Report, page 202
[46] FC NOMIS Transfer Report, page 202

2.7 Assessment of needs and risks FC

We do not know if a Basic Custody screening was carried out on FC which would have highlighted his needs and the risk of harm he posed to others. Neither do we have a copy of the CSRA, although the NOMIS Transfer Report extract assesses him as a standard risk with no concerns. No other significant assessments were undertaken in the three weeks from FC's reception to the date of the incident.

FC had been in HMP Durham and other prisons in the area and was known by a number of staff we interviewed as part of the investigation. We were told that he had a reputation of being aggressive and physically intimidating. Apparently, he also had a traumatic childhood. Prison Officer 1 told us that:

'I think that FC will kill someone one day. He had a very poor background – his mother used to dress him up as a girl and pass him around paedophiles. I know this because he talks openly about it and other staff have also told me. This is why he acts as a child in a man's body. He does not always know what he is doing.[47]'

Prison Officer 2 added in his interview:

'FC was a big lad. He had a tattoo down the side of his face and tried to be intimidating. I knew him from a previous sentence. You needed to stand up to him, but he knew where the line was. He was more dangerous to prisoners than to staff. He was very aggressive. He had a very poor upbringing and didn't have much of a chance himself.[48]'

Prison Officer 3 echoed this assessment:

'FC was a bully, anti-Prison Officers, spoke when spoken to, not polite and not a very nice guy. Because of his size, he was quite intimidating.[49]'

Custodial Manager 1 acknowledged that FC, whilst problematic, was not unique given the profile of prisoners in HMP Durham:

'FC was a troubled young man. He was big in stature but vulnerable in terms of being influenced by others. He was very spontaneous. I knew him for a number of years. I had a decent rapport with him. There are a lot of dangerous prisoners in the system but at the time he was just another prisoner.[50]'

Senior Prison Officer 1 told us:

'[FC] was quite well known throughout the staff. Someone to keep an eye on. He was seen as potentially dangerous to prisoners and staff. Security used a system called VIPER to identify the top 10 prisoners – prisoners of note or interest. I believe he's been previously involved in violence. We used to get security briefings at the time, not just the most violent offenders are, but the most notable ones who've

[47] Interview with Prison Officer 1 on 25 May 2022
[48] Interview with Prison Officer 2 on 24 May 2022
[49] Interview with Prison Officer 3 on 25 May 2022
[50] Interview with Custodial Manager 1 on 25 May 2022

maybe had the most adjudications for violence, or incidents of self-harm. VIPER could be used as a temperature gauge on who we were housing at the time.[51]*'*

It was clear from the comments of staff that they were aware that FC had the potential to be violent. However, no special measures were put in place to manage his behaviour.

2.8 Healthcare: FC

The Clinical Reviewer examined FC's medical records and noted that during previous sentences he had contact with drug treatment and Mental Health services. His attendance with mental health appointments was, however, sporadic.

Despite a lack of comprehensive mental health assessments, in June 2006, a letter from the Consultant Psychiatrist was written to the Forensic Psychiatrist in HMP Durham, following an urgent referral from a nurse who had sight of some material written by FC, the material 'is heavy laden with graphic murderous images and threats.[52]

The letter goes on to suggest the possibility of treatment in a specialist hospital to begin with 'presumably under Mental Health Act detention (47/49) for Psychopathic Disorder'.

Section 47 of the Mental Health Act (MHA), 1983 (amended 2008), is the removal from people serving prison sentences to hospital. Section 49 is a restriction direction which can be placed on a patient transferred from prison to hospital under Section 47.

Following a Mental Health review on 27 November 2007, medical notes state a referral to personality disorder services (DPSD) was pending[53]. On 9 April 2009 it is noted FC was 'not suitable for PD services, no evidence of MH issue.'[54]

The clinical reviewer concluded that there was no evidence in the notes of any comprehensive risk assessments, or the management of or mitigation of any risks that may have been identified.[55]

His most recent spell in prison on 26 March 2015 included a healthcare reception screening, including AUDIT (Alcohol Use Disorders Identification Test), urine screening and a referral to mental health (which he declined). This is consistent with NICE Guideline NG 57, Physical Health of People in Prison, November 2016,

[51] Interview with Senior Prison Officer 1 on 25 May 2022
[52] Clinical Review on FC whilst a serving prisoner at HMP Durham carried out by Cheryl Carson dated 30 June 2022
[53] Clinical Review on FC whilst a serving prisoner at HMP Durham carried out by Cheryl Carson dated 30 June 2022
[54] Clinical Review on FC whilst a serving prisoner at HMP Durham carried out by Cheryl Carson dated 30 June 2022
[55] Clinical Review on FC whilst a serving prisoner at HMP Durham carried out by Cheryl Carson dated 30 June 2022

2.9 The events of 16 April 2015

We have examined the police narrative of the CCTV footage of the area close to the incident, reviewed a number of still photographs taken from the footage, read police witness statements and interviewed witnesses.

On the morning of 16 April 2015, half of A Wing's prisoners (which comprised five landings) were unlocked from their cells for association to enable them to complete domestic activities including showering. These prisoners included SR and FC. Some prisoners would have chosen to remain in their cells, leaving approximately 60 – 80 prisoners to be supervised. Decisions about unlocking prisoners are informed by the need to have a sufficient level of staff to manage association safely.

At the time the minimum staffing level was a Senior Officer (Senior Prison Officer 1) and four prison Officers (Prison Officer 4, Prison Officer 3, Prison Officer 2 and Prison Officer 1). A Custodial Manager (Custodial Manager 2) was in overall command. Staff were deployed to supervise association and patrolled Landings 2 and 4 which gave them oversight of the wing and showers in particular, although Prison Officer 2 did point out to us that there is a curve on A Wing which meant some sightlines were obscured.

Because the showers on Landing 2 were out of order (which SR would normally have used) he went to take a shower in the shower recess on A4 Landing which has six cubicles. A number of other prisoners (including FC and two other prisoners who were originally suspected of being involved in the assault) were also going in and out of the showers. Three prison officers (Prison Officer 4, Senior Prison Officer 1 and Prison Officer 1) were in the vicinity of the showers around the time of the incident to ensure that that the activity was carried out in an orderly and safe manner, although not all were present all of the time. At times the officers were seated. As the showers only had six cubicles, prisoners tended to congregate outside the entrance awaiting their turn. For reasons of privacy and decency, officers do not normally enter the showers when prisoners are present. This applies particularly to female members of staff, two of whom were on duty on the day in question.

FC and SR entered the showers around the same time as each other. FC then left the showers carrying a wet sweatshirt and spoke to staff. He then went down the stairs and gave the sweatshirt to Prison Officer 2 who was on Landing 2 and asked for a replacement. Shortly after this, another prisoner who was SR's cell mate left the showers and raised the alarm that SR had been assaulted.

Prison Officer 1 produced a statement[56]. She said that FC had joked with her and Senior Prison Officer 1 about leaving the shower in a wet top – he claimed that he had accidently lent against a tap. She stated that a prisoner (SR's cell mate) came out of the shower to tell her that SR was unconscious. She went into the showers

[56] Statement of Officer Prison Officer 1

and found SR. She said she raised the alarm and shouted for help. Other prison staff and Hotel 1 (Nurse 1) responded immediately. On interview, Prison Officer 1 told us that although on her statement she had timed going into the shower at 10:55, it could have been two or three minutes either side of this[57].

A summary of the timeline (taken from CCTV footage narrative drawn up as part of the police investigation) is as follows:

- SR waits for cell mate to arrive so he can borrow shower gel. There appears to be no hostility toward him from other prisoners until FC walks past him on the stairs on the way to the showers and appears to knock him in the genitals. However, they subsequently pass each other, and nothing is said, and SR does not appear to be concerned. The police narrative then states that words do appear to be exchanged but there is no aggression.
- 10:47:50 FC enters showers
- 10:48:14 SR enters showers
- 10:49:58 FC exits showers carrying wet jumper
- 10:50:56 FC re-enters showers
- 10:51:28 FC exits showers

A more detailed narrative of the CCTV footage is shown at Annex 1.6.7[58]. This narrative is a combination of the separate narratives prepared by the police of the respective movements of SR[59] and FC[60] (there are some inconsistencies in the timings on the narrative which are noted).

According to Prison Officer 1, at around 10:55 another prisoner left the showers and informed her that SR was unconscious in the showers. SR's mother said that she had been informed that her son was on the floor for 15 minutes before he was discovered. It is not possible to identify from the CCTV how long he was there. The narrative by the police records that SR entered the shower at 10:48:14 and that FC was already inside. FC left the showers at 10:49:58 and re-entered them briefly for half a minute. It is not known precisely when the assault occurred, but it seems likely that as FC told Prison Officer 1 that he waited until she had left the area, that the assault occurred between 10:50:23 and 10:50:49. However, we cannot rule out assaults taking place at any or all times when both RS and FC were present.

The last entry from the narrative of the CCTV was at 10:52:52, when FC was seen to walk down to the 2's landing.

We were advised by Prison Officer 3 that:[61]

'FC came down the stairs and asked for a new sweatshirt so I got one for him. A little while later, I heard the alarm and went up to the 4s[62]'

[57] Interview with Officer Prison Officer 1 on 25 May 2022
[58] Chronology 16 April 2015
[59] Durham Constabulary Narrative of CCTV - SR
[60] Durham Constabulary Narrative of CCTV - FC
[61] Interview with Officer Prison Officer 1 on 25 May 2022
[62] Interview with Prison Officer 3 on 25 May 2022

This would suggest that SR would have been on the floor for approximately five minutes.

Prison Officer 1 stated that in her interview with us that:

'I became aware of the incident when SR's cell mate, told me that SR was unconscious in the shower. I shouted "Staff", pressed the alarm bell and made a call over the radio. All staff were alerted so I felt it was correct to enter the shower area even though prisoners were showering, and I was a lone female. Prisoners were still showering, and I told them to cover up. I could see blood and water flowing down the drain. I did not put down in my statement that I asked for health care. I am not sure if the Code Blue system was in place then. The control room asked for acknowledgement from Victor 2 and Oscar 1. Oscar 1 would have responded and acted as Incident Bronze. The control room would have called the ambulance. It may have been that [Custodial Manager 2] who told the control room. I felt that the ambulance arrived very quickly.[63]'

Custodial Manager 2 wrote in his statement that he responded to the alarm and called a code blue (medical emergency)[64]. Senior Prison Officer 1 and Prison Officer 3 and Prison Officer 4 also arrived to assist SR who was in the showers unconscious with blood coming from his head and appeared to be in the recovery position. Healthcare staff and then paramedics arrived.

Prison Officer 1 also added in her statement that she was told by the wing cleaner that FC was responsible for the attack because SR was in debt. Prison Officer 1 said that SR had not previously raised this as a concern[65]

The narrative ends when FC leaves the area and it would have been useful if we could see the actions that staff took when the alarm was raised.

CCTV was available to trained staff, who could use the footage for evidential purposes. It would be unusual for staff to watch cameras during association periods as they would be expected to engage with prisoners.

2.10 The Medical Response

Nursing staff responded to the Code Blue and attended with emergency bags and commenced immediate life support. The Clinical Reviewer noted that one of the nursing staff identified that SR had pinpoint pupils and as a precaution administered intramuscular Naloxone. Pinpoint pupils can indicate an opiate overdose which can also cause respiratory depression. Naloxone can reverse these effects - this was very good practice, as SR was having difficulty breathing.

Nurse 1 was the first member of health care staff to attend the incident. She told us in her witness interview:

[63] Interview with Officer Prison Officer 1 on 25 May 2022
[64] Statement of Custodial Manager 2
[65] Statement of Officer Prison Officer 1

'I remember the incident well because of the level of violence used I responded to a code blue in A wing showers. I was possibly Hotel 1, which carries a radio and responds to incidents. One of the Officers said, "it is alright, he has just had a fit in the showers". It was not a fit – he was not jerky. When I entered the showers, I could see that he was lying awkwardly with his head under a shower door. Because of the head injury, I could not move him. I tried a Guedel airway, but I could not get it down his throat. I tried a nasal pharyngeal airway, but this was not successful. I did not want to risk causing damage when I met resistance. I used oxygen.
An ambulance was called. I am not sure whether it was designated a category 1 or category 2. Category 1 requires a response as soon as possible, but a category 2 allows 18 minutes.[66]*'*

Nurse 1 added more detail including apparent tension between the two paramedics and concern about the way in SR was transferred to the ambulance.

'During that time, we were trying to protect his airway to preserve life. There is a tension between protecting the airway and avoiding a spinal injury. When the ambulance arrived, they used a Venflon which is a small flexible tube that is inserted into the vein to give medication or fluids. There appeared to be a disagreement between the paramedics as one criticised the other for putting the bandage on too tight. I asked if they had a board and when they said no, [Health Support Worker 1] asked if they would like her to support his head as they went downstairs, but they declined. We had used a mask that gave a higher concentration of oxygen. We monitored his blood pressure and oxygen saturation. He was put onto the ambulance and taken to hospital. We normally accompany the prisoner to the ambulance.'[67]

Health Support 1 and Clinical Team Leader 1 from Health care also attended as this extract from the medical record dated 16 April 2015 on SR confirms:

Health Support 1 and I [Clinical Team Leader 1] ran to attend the call via A wing electronic gate in order to obtain the emergency equipment … [we] ran up to A4 shower area where Nurse 1 was with the patient. A blue light emergency was called as the patient was unconscious and had bruising around his head and neck. Nurse 1 tried to maintain his airway by use of a guedel airway, but this was not tolerated by SR. Staff remained with him until the ambulance left. I informed [the SO] the ambulance would need to be informed that they will require a collar and stretcher as his head and neck would need to be immobilised due to the head injury and we could not rule out any spinal injury. However, he was transferred from the floor to a chair without support and taken to the ambulance.[68]

Health Support 1 told us that:

'I was concerned because the ambulance staff did not bring a board or collar.'

[66] Interview with Nurse 1 on 24 May 2022
[67] Interview with Nurse 1 on 24 May 2022
[68] Clinical Records from SystmOne for SR

She also told us that she offered to support the patient's head.[69]

Unfortunately, we were not provided with the time of the ambulance's arrival and departure from the prison, neither were we given the Control Room logs detailing the timings of the Code Blue calls. Nurse 1 estimated that the ambulance took between 10 and 20 minutes to arrive. We did, however, walk the route the ambulance and paramedics would have taken on arrival at the prison gate to the scene of the incident. This route was relatively short and straight forward.

2.11 Management of SR after the assault

SR was taken to Hospital A. CCTV identified three suspects (two of whom were quickly eliminated from police enquiries) and detailed notes were taken by the healthcare staff involved.[70]

At 12:40 Family Liaison 1, (Chaplain and Family Liaison Officer) telephoned the mother of SR to tell her that SR was in hospital. At 16:30 Family Liaison 1 also visited the hospital and met with his mother, and other family members. SR was still unconscious and on a ventilator. Family Liaison 1 spoke to the duty nurse and bed watch staff and also offered to pray for SR.

The Serious Assault Questionnaire completed on the day of the incident suggests that the assault may have been debt related.[71] The Fact-Finding Report on the incident competed on 23 April 2015 commented that FC had an appalling record in custody.[72] He had periods of segregation for threats of violence and had an issue with sex offenders, which may have been a factor in the assault on SR, despite him being successful on appeal against this conviction.

2.12 Management of FC after the incident

FC was taken to SACU not under restraint on the grounds of good order or discipline as a result of the alleged assault and was assigned cell G1-002 at 11:57. On 21 April 2015, FC was transferred to HMP Leeds[73].The Cell Sharing Risk Assessment on this occasion was recorded as High Risk and referenced the assault in the showers, previous dirty protests, weapons and threats to staff[74].

Following a police investigation, FC was identified as the perpetrator of the assault. His original defence was that he was attacked in the shower room. However, in the witness statement of an Officer he states that on 7 July 2015. he overheard a conversation between FC and another prisoner where he says that he had a grudge against SR because he had 'slyed' him by disrespecting him by punching him in the

[69] Interview with Clinical Team Leader 1 and Nurse Angela Race on 24 May 2022
[70] Clinical Records from SystmOne for SR, p 4 - 5
[71] HMP Durham - Serious Assault Incident Questionnaire, undated
[72] HMP Durham - Fact Finding Report into a serious self-harm and/or assault dated 23 April 2015
[73] FC NOMIS Transfer Report, page 201 - 202
[74] FC NOMIS Transfer Report, page 211

back of his head (it is not clear whether this incident took place). FC said that he had retaliated by attacking SR in the showers[75]. An alternative possible explanation was given to us by Custodial Manager 1 – that FC carried out the assault on behalf on someone else over unpaid debts[76].

Custodial Manager 2 described in his police statement and interview as part of this investigation how he took a lead in preserving the evidence connected to the assault and writing up the documentation[77]. FC changed his plea to guilty before trial. He was sentenced to a term of imprisonment for the offence of Grievous Bodily Harm in September 2016.

[75] ED1501316 PO Statements
[76] ED1501316 PO Statements
[77] ED1501316 PO Statements and Interview with Custodial Manager 2 via Teams on 1 June 2022

Part 3 Issues examined during the Investigation

3.1 How well were SR's physical and mental health needs assessed and treated?

SR did not have significant health needs up to the time of the assault on him. Induction and follow-up health checks were completed correctly in line with protocols in place at the time.

Finding

In summary, SR received healthcare in HMP Durham equivalent to that which he would have had were he in the community.

3.2 Were the needs and risks of SR correctly identified?

We were provided with little formal documentation about needs and risks; but records made available to us and information from staff who dealt with SR during his time in HMP Durham paint a picture of an immature man, who at times, struggled to cope with the requirements the prison regime demanded of him.

Finding

We take the view that the needs and the risks SR posed were adequately identified by prison staff; they assessed him correctly as a young man who, whilst immature, did not present a significant risk to himself or others.

3.3 How well did staff respond to the assault on SR on 16 April 2015?

After being told that SR was unconscious in the shower, Prison Officer 1 did not hesitate to enter the shower cubicles on her own (having called for back-up) to tend to SR. Once the alarm was raised, uniformed staff responded very promptly to the emergency.

PSI 03/2013 sets out the framework for calling a medical emergency consistently over the establishment radio network in all prisons. When a prisoner is found unconscious then, the member of staff should report a 'Code Blue'. The Communication/Control Room should automatically call an ambulance and await updates from the scene. Where available, the Duty Nurse attends with necessary equipment and assesses the patient and the Gate staff prepare to receive ambulance. It is better to act with caution and request an ambulance that can be cancelled if it is later assessed as not required,

Staff would be arranged to escort the ambulance within the prison and escort staff and equipment should be arranged in case the prisoner needs to be taken to hospital. [78].

As far as we can ascertain the required actions set out in PSI 03/2013 took place following the discovery of SR in the showers. Prison Officer 1 could not remember whether the Code Blue system was in place at the time, but immediately after the incident she wrote a statement that stated:

I entered the showers and saw there was a prisoner unconscious on the floor with blood running from his person. I raised the alarm shouted for staff assistance and asked Hotel 1 (the nurse) to attend for a prisoner unconscious.[79]

Custodial Manager 2 recorded in his statement that he called for urgent healthcare assistance and used the 'Code Blue' term.[80]

We requested both the Control Room log and the Gate Book relating to the date of the incident, but these were not supplied. The Control Room log would have contained details the 'Code Blue' report and the request for an ambulance. The gate book would have provided details of the arrival and departure of the ambulance. Consequently, we are not able to state categorically whether the ambulance was called promptly or whether it was escorted properly. However, none of the documents or witness statements suggest that there were delays in summoning and obtaining the emergency services.

Health care staff gave immediate (possibly lifesaving) first aid and assisted with the handover of SR to paramedics. There were, however, concerns raised about the way in which SR was taken to the ambulance without a neck brace or board to support him.

Whilst attention was given to SR, proper steps were also taken to manage the other prisoners who were on association.

Finding

We cannot be certain if there was an unacceptable delay in calling the emergency Code Blue for medical assistance because we did not have the relevant records. We also note that initially an officer thought that SR had a fit. However, we take the view that prison and in-house health care staff responded effectively and professionally to the incident once they realised the seriousness of it. Some concerns were expressed by the health care staff about the way SR was transferred to the ambulance by paramedics.

[78] PSI 03/2013 Medical Emergency Response Codes
[79] Statements – Full disclosure (redacted)
[80] Statements – Full disclosure (redacted)

3.4 How well were FC's physical and mental health needs assessed and treated?

In the short time FC was in HMP Durham his physical health needs were correctly assessed. There were long standing concerns about the mental health of FC and the impact that could have on other people who might be at risk from him. By the time of he arrived in HMP Durham in March 2015 these concerns appear to have declined and it is unrealistic to expect that a further assessment would have been instigated in the short time leading up to the incident

Finding

In summary, FC received healthcare in HMP Durham equivalent to that which he would have had were he in the community, although the failure to complete full psychiatric assessments during earlier sentences may have been a missed opportunity.

3.5 Were the needs and risks of FC correctly identified?

FC was in HMP Durham for a relatively short time and as in the case of SR, there were few formal assessment documents available. We were, however concerned about the Cell Sharing Risk Assessment. There are considerable mandatory actions in PSI 09/2011 Cell Sharing Risk Assessment that relate to the assessment of individuals for the risk that they pose to themselves, to others and/or from others.

FC had been previously assessed as high risk on 9 March 2014 as a result of a suspected assault on his cell mate on 7 March 2014[81]. However, on 26 March 2015, when he arrived at HMP Durham from Newcastle Court, the calculated result from his Cell sharing risk assessment was 'Standard risk no concerns'[82] Prison Officer 2 thought that FC did may have been allocated a single cell at some stage because of his risk[83]. However, at the time of the incident FC was sharing a cell with another prisoner.

We cannot assess whether staff followed the procedures in PSI 09/2011 to identify prisoners who pose a risk to or from others with regard to cell sharing because although we have the outcome of the cell sharing risk assessment for FC, we do not have the assessment itself. As a result, we are unaware whether staff checked relevant documents for evidence of risk, for example, the Person Escort Record, pre-sentence reports, NOMIS, and clinical records.

Based on the information available to the investigation, the CSRA assessment of standard does not appear to have been reasonable because of FC's history of assaults on other prisoners and staff and of deliberately setting fire in prison. Violence in prison, and in particular repeat violence, indicates the person is likely to continue to be violent. The PSI states involvement in more than two violent incidents

[81] FC CSRA March 2014

[82] FC (pot perp) NOMIS transfer report - redacted, p212

[83] Interview with Officer Prison Officer 2 on 24 May 2022

would definitely demonstrate increased risk. It is known that previous convictions for arson are a very strong indicator that a prisoner may be violent towards a cell mate. The risk from those who set fires in their cell is obvious, but any history of arson indicates increased risk.[84]

Finding

The risk that FC posed to other prisoners was not clearly recorded and articulated.

Recommendation 1 to HMP Durham

In order to reduce the risk of harm posed by prisoners to other prisoners' Cell Sharing Risk Assessments should be better recorded and steps to mitigate risk of harm clearly stated. In addition, there should be a system for retrieval of the document upon request.

3.6 Could the assault have been prevented?

The Residential Risk Assessment at HMP Durham included an index contains 35 Safe Systems of Work (SSoW)[85]. The most relevant to this incident was the section: '7 Association Patrol' which included assaults on staff and prisoners, bullying, potential weapons and blind spots among the risks during association.

The control measures identified included 'Adequate staffing levels, Adequate Supervision / Staff Patrol, Competent Staff, Briefings / LSS (Local Security Strategy), CCTV, SSoW 3 & 10 Association, Staff interaction, Violence Reduction Strategy, Zero Tolerance Policy (Drugs), Communications / Radios / Alarm Bells'

Given the importance of competent staff, adequate staffing levels and adequate supervision levels and staff patrols, staff were not always able monitor prisoners' movements effectively. For example, in her police statement, Senior Prison Officer 1 stated that she did not know how often FC went into the shower as it was not unusual for them to do this as they had to wait for a cubicle to become available[86].

We were able to view a limited amount of CCTV which included footage of staff outside the showers. We were also able to study the CCTV stills and read the police narrative and it is apparent that the entrance to the shower where the assault took place was not observed constantly. The first appearance of staff is at the start of the recording at10:35:10 when camera 7 shows Prison Officer 1 and Senior Prison Officer 1 sat talking on level 4 outside the showers. Obviously, we do not know how long they were there before that. The chairs are located near the 'red box', which reduces visibility of the right side of the landing from a seated position when looking away from the shower area. Although the staff were alert and regularly looked up and down the landing, there was no active engagement with prisoners, although they did chat with prisoners when spoken to. Supervision would have been improved had staff regularly patrolled in all areas, talked to prisoners, gaining trust and building rapport.

[84] PSI 64/2011 Management of Prisoners at risk of harm to self, to others and from others (Safer Custody), paragraph 2.8
[85] HMP Durham Residential Risk Assessment
[86] ED1501316 PO Statements, page 8

There were considerable movements in and out of the shower area. Both Officers were seated for four minutes at the start of the retained CCTV recording and were later joined by Prison Officer 4. Senior Prison Officer 1 then leaves for about a minute, but then three Officers are together in the same area. All three then leave the area ten minutes later, with only Prison Officer 1 returning one minute later.

Prison Officer 1 submitted an intelligence report on 07July 2015 stating that FC said:

'I am sorry that it was you miss but I did wait until you went to get a cell bell or something so that you weren't there.[87]

Given the movements of FC, it is likely that the assault occurred at the time that Prison Officer 1 left the area outside the showers.

We were told that at the time of the incident there had been a reduction in minimum staffing levels for association from one SO and five Officers to one SO and four officers. Witnesses told us that this resulted in difficulties in ensuring that all areas of the wing could be observed and supervised by staff. Custodial Manager 2 told us:

'… in 2015 the staffing levels had not long been reduced. I'm pretty sure if I recall correctly that we had gone from a SO and five staff to a SO and four staff. And that was quite controversial at time. That's the reason I remember it because there was there was actually 5 landings on A wing. So, if you've got four officers, it was, it was like it didn't seem at first glance to be appropriate.'[88]

Prison Officer 4 commented:

'When I started it was completely different with more staff. We had an officer outside the shower room with a list and prisoners had to book a shower. They had a 10-minute slot for showers and telephones. If you didn't turn up at the right time, you lost your slot, and it gave them some responsibility. It was controlled and safer. You reduce the risk with more staff.[89]*'*

Durham had a local Violence Reduction Policy, which included a section on Challenging Anti-Social Behaviour (CAB)[90]. It was emphasised that 'staff must engage with prisoners rather than just observe'. There were three stages: the first included monitoring of behaviour for one week, the second applied when there was a proven adjudication or having a history of violent attacks and the third stage where a prisoner required location in the SACU and transfer out of the prison.

FC had a very violent background, both in and out of prison. Whilst the national Incentives and Earned Privileges policy at that time required that prisoners should be placed on the standard regime level on arrival[91], his previous prison behaviour could have triggered a CAB review on arrival to establish that previous behaviour in prison would not be tolerated. Two of the incidents that resulted in his location in the SACU,

[87] Mercury redacted, page 5
[88] Interview with Custodial Manager 2
[89] Interview with Prison Officer 4 on 25 May 2022
[90] HMP Durham Violence Reduction Strategy
[91] PSI 30/2013 Incentives and Earned Privileges

could have resulted in a CAB being started, but there is no evidence that this happened. This was a missed opportunity as it might have resulted in FC being aware that there were consequences to his behaviour and alerted staff to his tendency towards violence, which may have increased their monitoring of his movements during association.

Custodial Manager 2 told us:

'…as far as I'm aware, he wasn't being monitored through safer custody for any bullying strategies or anything like that.'

He also added:

'[In previous sentences] we had spoken about FC and what he had been involved in. I couldn't remember if it was threats to staff or if he'd actually been involved in violence. I can't recall, but I can remember that he had been talked about in residential meetings.[92]*'*

Finding

The failure to follow the procedures set out in the Violence Reduction Strategy was a significant failing. If steps had been taken to interrupt FC's aggressive behaviour the likelihood of the assault taking pace would have been reduced.

Recommendation 2 to HMP Durham

In order to reduce the risk of violence to prisoners the Violence Reduction Strategy should be monitored by managers to ensure that all prisoners to whom it applies are included and steps taken to reduce their likelihood of potential violence.

Finding

There is a fine line between ensuring safety and ensuring privacy when supervising prisoners in an antiquated Victorian prison which does not have modern in-cell facilities. FC took the opportunity to assault SR when the entrance to the showers was probably not monitored by staff. Given the fact that staff could not physically go into the cubicles he still may have carried out the assault, but their temporary absence may have emboldened him. We are also concerned that staff may have been conditioned into accepting prisoners entering and leaving the showers on a frequent basis. We were not completely satisfied that the area was being properly supervised when staff were present.

Finding

We found that the level of staffing on the wing at the time made oversight difficult of a crowded and at times chaotic situation.

Recommendation 3 to HMP Durham

In order to reduce congestion in and around showers and make observation easier HMP Durham should introduce a prisoner reservation booking system for the use of showers.

[92] Interview with Custodial Manager 2 via Teams on 1 June 2022

Recommendation 4 to HMP Durham

HMP Durham should review the minimum staffing level needed to safely oversee prisoners taking part in association.

3.7 Was FC managed properly after the incident?

Staff were quickly able to identify FC as the potential perpetrator of the assault and were able to locate him in the SACU and follow appropriate chain of custody procedures when collecting his clothing and shoes.

Finding

FC was managed properly after the incident and commendable efforts were made to secure the evidence required to help secure a conviction.

3.8 Were the correct post incident policy and procedures followed?

PSI 11/2002 Incident Reporting System

PSI 11/2002 requires that establishments report all assaults. An assault is classified as serious if it is a sexual assault, it results in detention in outside hospital as an inpatient, requires medical treatment for concussion or internal injuries or is a fracture, scald or burn, stabbing, crushing, extensive or multiple bruising, black eye, broken nose, lost or broken tooth, cuts requiring suturing or similar treatment, bites or temporary blindness.

A serious assault falls under the scope of Group A incidents, which are incidents that require reporting by telephone immediately.

There is no doubt that the assault on SR was a serious assault. SR suffered loss of consciousness as reported on the statement of Prison Officer 1 and was admitted to outside hospital as an in-patient. The investigation was supplied with a copy of the entry on the Incident Reporting System; this confirms that the incident was treated as a serious assault and reported by telephone. [93]

PSI 15/2014 Investigations and learning following incidents of serious self-harm or serious assaults

The first mandatory action in PSI 15/2014 was that Governors must ensure that all the relevant staff are aware of the requirement to investigate the circumstances of incidents of serious assaults (on staff, prisoners and others) and serious self-harm.

It appears that key staff had knowledge of this requirement. The PSI also required that Governors must ensure that all incidents of serious assaults (on staff, prisoners and others) and serious self-harm are telephone reported to the NOU in line with PSI 11/2012 Incident Reporting System; and investigated at an appropriate level; and that any lessons are learned from the incident.

[93] Daily Report 17-4-15

Governors were also required to ensure that when requested by Equality, Rights and Decency (ERD) Group, the serious assaults questionnaire (annex B to the PSI) was completed and returned to ERD Group within three working days of the incident being reported. Where the ERD Group indicated that an independent investigation may be required, all documentation relating to the prisoner(s) involved in the incident (for example, core record, medical record, and Assessment, Care in Custody and Teamwork or Cell Sharing Risk Assessment forms) must be retained. The questionnaire was completed in full but was undated [94].

On 22 May 2015, the ERD Group informed HMP Durham that an independent investigation might be required and that they should 'ensure that [SR's] F2050, along with all other documents that are relevant to the assault incident, are collated and held securely. It would be helpful if you could confirm that this has been done'[95]. Unfortunately, this investigation has found, not all documentation relating to SR and FC was retained. The ERD Group amended the procedures in 2019. An email is now sent to prisons when notifying them that an independent investigation may be necessary following an incident of serious assault requesting that a full copy of the victim's and the perpetrator's records are gathered and stored securely.

Lastly the PSI required that in all cases in which a questionnaire was completed and returned to ERD Group, Governors must ensure that a copy of the investigation report is submitted to ERD Group not later than one week after the investigation has been completed. An investigation report was completed on 23 April 2015, but it has not been possible to establish when this was submitted to ERD.[96] The report briefly covered all the aspects identified in PSI 15/2014, paragraph 20.47

PSO 1300 - Investigations

PSO 1300 distinguishes between simple investigations and formal investigations with the emphasis being on simple investigations wherever possible.

However, the PSO 1.6.1 requires that a formal investigation will be necessary if 'from the findings of a simple investigation or from the outset, it appears that there was serious harm to any person'.[97] As the original investigation report was identified as a fact-finding report, it was unlikely to be a formal investigation. The fact-finding report failed to examine the supervision of the area and whether the assault could have been prevented.

HMP Durham's Violence Reduction Strategy suggests that it may be necessary to undertake further internal investigations in order to learn lessons, prevent future occurrences and improve local delivery of safer custody.[98] This did not happen.

Any alleged crime can be reported to the police either directly or through the local Police Intelligence Officer. Where the victim of a violent incident is a prisoner, their wishes must be considered. There are approximately 15,000 violent incidents in

[94] Serious Assault Questionnaire, undated
[95] E mail from Safer Custody Casework Team to Andy Smith, dated 12 July 2022
[96] Investigation Report dated 23 April 2015
[97] PSO 1300 Investigations Paragraph 1.6.1
[98] HMP Durham Violence Reduction Strategy, page 2

prisons each year. It would place a significant and unreasonable demand on police resources to investigate all these incidents. In many cases a more immediate and effective outcome would be gained by use of internal systems. However, it is recommended that the more serious violent offences are referred to the police. Notification to the police and the subsequent prosecution was appropriate in this case.

PSI 64/2011 - Safer Custody

PSI 64/2011 requires that all prisoners must be asked to nominate a next of kin who must be updated regularly. His core record shows that SR had been asked and had identified a next of kin, namely his mother.[99]

The PSI also requires that where prisoners have suffered sudden life-threatening harm, the prisoner's wishes on whom they would like to be contacted must be ascertained where possible. In the event that the prisoner is unable to communicate their wishes, the prison must contact the nominated next of kin who must be given an accurate account of what has happened. As SR could not communicate his wishes, SR's mother was contacted but documentation does not state what information was passed on.

The PSI describes that engagement with next of kin is required for prisoners who have suffered a rapid deterioration in their physical health regardless of whether death is likely to occur as a result of injuries. It is good practice for communication with the family to be recorded in a FLO log. As early reports from hospital indicated that the prognosis was very poor, a Family Liaison Officer (FLO) Family Liaison 1, a Chaplain was appointed. A log was started which showed that he made contact with SR's mother at 12:30 and advised her to go to the hospital. He then went to the hospital at 16:30 where he met with SR's mother and his extended family. He offered pastoral support whilst SR was being examined by doctors. He then visited SR with SR's mother and in total spent one and a half hours there. On 21 April 2015, he telephoned SR's mother to enquire how she and SR were and asked whether she would be happy to be contacted by another FLO. On 23 April 2015, the new FLO telephoned SR's mother and arranged to visit the hospital later. He found the family very upset and stayed with the family's consent whilst they met with the nurses and doctors. The family advised him that the police had also appointed a Family Liaison Officer, who was updating them on progress with the case. A call was made on 6 July, to enquire about SR's progress, but there were no further updates.

When the investigators met with SR's mother, we were advised that there was a FLO appointed, but whilst they explained what would happen at court and communication was adequate at the beginning, the FLO did not engage with the family once FC was convicted.

Incident Management Manual

Like PSI 11/2002, Chapter 3 of the Incident Management Manual requires that an assault is reported immediately if it is a serious assault. Any assault, including a

[99] SR Core Record - redacted

fight, is classified as serious if it is a sexual assault; results in detention in outside hospital as an inpatient; requires medical treatment for concussion or internal injuries; or the injury is a fracture, scald or burn, stabbing, crushing, extensive or multiple bruising, black eye, broken nose, lost or broken tooth, cuts requiring suturing or similar treatment, bites, or temporary or permanent blindness.

As the prison was compliant with PSI 11/2002, we are able to state that the prison was also compliant with the incident management manual.

Staff Care

All violence in prison is clearly unacceptable and Prison Service managers have a duty of care in terms of supporting staff when they have been involved in dealing with a violent incident. This assault was distressing for all the staff involved. Custodial Manager 2 told us that he held a debrief for staff immediately after the incident focussed mainly on practical concerns. However, in terms of more personal support for staff, the officers we interviewed told us that they were aware of the service offered but had not availed themselves of it.

Finding

A full investigation was not completed when it became apparent that SR had sustained serious harm as a result of his life-changing injuries.

Finding

Few if any staff accessed staff care services following the incident.

Recommendation 5 to HMPPS

As a considerable time may pass before an Article 2 investigation is commissioned, HMPPS should clarify whether the prison is responsible for completing a full investigation where serious harm to an individual has been sustained.

Recommendation 6 to HMPPS

As the impact on staff well-being of traumatic incidents may not be immediately apparent, all staff should be actively encouraged by their managers to access staff care services following such incidents.

Part 4 The Inquiry Process

4.1 Investigations

No other investigations or reviews took place in relation to the incident.

4.2 The Independent Article 2 Investigation

Because of the length of time since the incident it proved difficult to collate all the relevant records relating to the two prisoners concerned. In addition, the memories of staff faded in the seven year between the incident and our interviews with them. This delay was also frustrating and distressing for the family of the victim

While we were very impressed with the professionalism and candour of the staff we interviewed, the process of liaison with HMP Durham was not without its difficulties. We experienced delays in obtaining documents we requested and despite reminders some never arrived. Communication with the prison was further hampered by the fact that our point of contact changed three times over the course of the investigation and on occasion we felt that they did not have sufficient authority to ensure the investigation was given sufficient priority by all relevant personnel.

Recommendation 6 to HMPPS

HMPPS takes steps to reduce the time between incidents and the commission of Article 2 Investigations.

Recommendation 7 to HMPPS

HMPPS should ensure that liaison between Article 2 investigators and prison is improved by ensuring that the member of staff in an establishment appointed to liaise: a) understands the nature of the Article 2 process, and b) is of sufficient seniority to direct staff and resources facilitate the investigation.

4.3 Public scrutiny

The Commission to conduct the Article 2 Investigation requires the provision of a view by the independent investigator about the appropriate element of public scrutiny in all the circumstances of the Practice case. Public scrutiny forms an important aspect of the investigative obligation under Article 2 of the European Convention on Human Rights. We have considered carefully whether the publication of the final version of this report will be sufficient to satisfy the requirement for public scrutiny or whether some further stage in the investigation is needed, such as a public hearing. We have reached the view that the publication will suffice and a public hearing is not needed in this case.

In reaching this view we have considered two questions. The first is whether there are serious conflicts in the evidence, which require the questioning of witnesses in a public setting to test the credibility of what they say. We do not think that there are any serious conflicts in the evidence.

The second question is whether the investigation has uncovered convincing evidence of widespread or serious systemic failures, such that a public hearing might be warranted to maintain public confidence. We have not uncovered any evidence of widespread or systemic failures.

We very much hope that our findings and recommendations will make a significant contribution to the improvement of the management of prisoners such as SR and FC in the future. We do not, however, consider that any further element of public scrutiny is required in this particular case.

Annexes

ANNEX 1 Documents reviewed and disclosed

1.1 Chronology

1.1.1 Chronology relating to SR and FC as at 22 February 2022

1.2 Prison Documents Relating to SR

1.2.1 SR NOMIS Transfer Report

1.2.2 SR Family Liaison Officer (FLO) log

1.2.3 SR Custodial Documents File Continued

1.2.4 SR Location Card

1.2.5 SR Reception Log

1.2.6 SR HMP Northumberland 14-day check

1.2.7 SR Person Escort Form

1.2.8 SR Cell Sharing Risk Assessment dated 6 October 2014

1.2.9 SR Review of Adult Male Prisoner's Categorisation – Licence Recall

1.2.10 SR Core Record

1.3 Prison Documents Relating to FC

1.3.1 FC NOMIS Transfer Report

1.3.2 FC CSRA July 2015

1.3.3 FC CSRA March 2014

1.3.4 FC Person Escort Form dated 26 March 2015

1.4 Interview Transcripts

1.4.1 Transcript of Interview with Prison Officer 1

1.4.2 Transcript of Interview with Prison Officer 2

1.4.3 Transcript of Interview with Prison Officer 3

1.4.4 Transcript of Interview with Prison Officer 4

1.4.5 Transcript of Interview with Senior Prison Officer 1

1.4.6 Transcript of Interview with Custodial Manager 1

1.4.7 Transcript of Interview with Custodial Manager 2

1.4.8 Transcript of Interview with Nurse 1

1.4.9 Transcript of Interview with Health Support Worker 1 and Clinical Team Leader 1

1.4.10 ED1501316 PO Statements

1.5 General Documents

1.5.1 HMP Durham Violence Reduction Strategy dated September 2011

1.5.2 Master Residential SSOW 26/3/15

1.5.3 Master Residential Risk Assessment 26/3/15

1.6 Documents about the incident

1.6.1 HMP Durham - Fact Finding Report into a serious self-harm and/or assault dated 23 April 2015

1.6.2 HMP Durham - Serious Assault Incident Questionnaire, undated

1.6.3 Incident Statement from Prison Officer 4, Prison Officer 1 and Custodial Manager 2

1.6.4 Near Miss -SR

1.6.5 Commissioning Letter from Andy Rodgers to Andy Smith dated 23 February 2021

1.6.6 MG5 2016 Police Report on FC

1.6.7 Chronology 16 April 2015

1.6.8 Durham Constabulary Narrative of CCTV - SR

1.6.9 Durham Constabulary Narrative of CCTV – FC

1.6.10 Durham Constabulary CCTV stills

1.6.11 Email from Safer Custody Casework Team to Andy Smith dated 12 July 2022

1.6.12 Daily Report 17-4-15

ANNEX 2 Documents reviewed but not disclosed

2.1 SR Prison Documents:

2.1.1 Custodial Documents file 2

2.1.2 Criminal Justice Act 2003 Licence

2.1.3 Remand Order 7 November 2014

2.1.4 Mercury Intelligence Report dated 23 March 2015

2.1.5 Mercury (redacted)

2.2 SR Health records

2.2.1. Clinical Records from SystmOne for SR

2.2.2 Clinical Review on SR whilst a serving prisoner at HMP Durham dated August 2022

2.3 FC Health records

2.3.1 Clinical Records from SystmOne for FC

2.3.2 Clinical Review on FC whilst a serving prisoner at HMP Durham dated August 2022

ANNEX 3 Documents reviewed and not annexed

3.1 HMPPS Policies

3.1.1 PSI 20/2015 – The Cell Sharing Risk Assessment

3.1.2 PSI 45/2010 – Integrated Drug Treatment Services

3.1.3 PSI 64/2011 – Management of Prisoners at risk of harm to self, to others and from others (Safer Custody)

3.1.4 PSI 23/2014 – Prison-NOMIS (Prison National Offender Management Information System)

3.1.5 PSI 06/2015 – Early Days in Custody

3.1.6 PSI 15/2014 Investigations and learning following incidents of serious self-harm or serious assaults

3.1.7 PSO 3050 Continuity of Healthcare for Prisoners

3.1.8 PSI 40/2011 Categorisation and Re-Categorisation of Adult Male Prisoners

3.1.9 PSI 03/2013 Medical Emergency Response Codes

3.1.10 PSI 30/2013 Incentives and Earned Privileges

3.1.11 PSO 1300 Investigations

3.1.12 PSO 2750 Violence Reduction issued June 2007

3.2 HM Inspectorate of Prisons Reports

3.2.1 Report of Unannounced inspection of HMP Durham (2 – 13 December 2013), Published May 2014

3.2.2 Report on an unannounced inspection of HMP Durham (3-14 October 2016), Published January 2017

3.2.3 Report of and Unannounced Inspection of HMP Durham

3.3 Independent Monitoring Board Report

3.3.1 HMP Durham, Annual Report of the Independent Monitoring Board to the Secretary of State for Justice (1 November 2014 to 31 October 2015)

3.4 Department of Health Policy

3.4.1 Models of Care for Alcohol Misusers (Department of Health/National Treatment Agency for Substance Misuse 2006)

ANNEX 4 Documents and information requested but not received

4.1.1 Extract from Gate Log showing when ambulance arrived and left HMP Durham, 16 April 2015

4.1.2 Control Room Log, 16 April 2015

4.1.3 FC Cell Sharing Risk Assessment on reception at HMP Durham